

BULLETIN

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**Preparing
surgeons
for
future
technology**



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About the cover...

All future-thinking surgeons must prepare for the imminent introduction of new technology, according to Richard R. Sabo, MD, FACS, ACS President. Hence, a major challenge for the College and its members is ensuring that all surgeons are well versed in the safe and appropriate use of new devices. Dr. Sabo indicated during his Presidential Address at the 2002 Clinical Congress. The text of his speech (p. 8) focused largely on the ways the College has worked to school surgeons in the use of innovative devices and on how the organization might expand its role in this area. (Cover photograph © Keith Brofsky/PhotoDisc.

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From my perspective

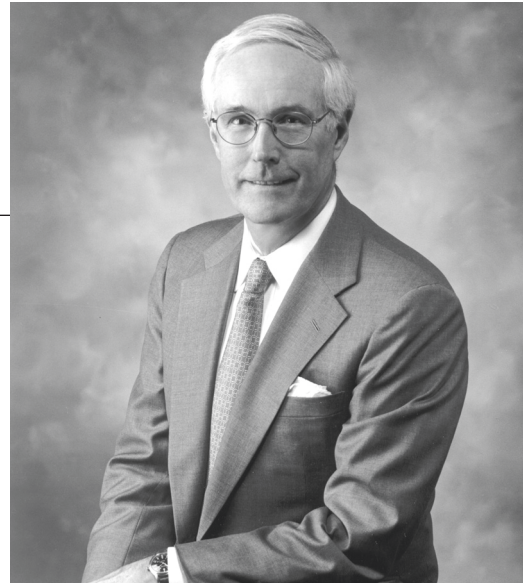
One of the most enjoyable and enlightening aspects of my job is visiting the chapters of the College and having the opportunity to learn about the issues that are affecting surgeons in their home states. At this point, I have visited more than 40 chapters and have continued to see evidence that one of the biggest problems surgeons are dealing with at the state level is professional liability.

While federal legislation would be extremely beneficial to surgeons who are having difficulty obtaining reasonable malpractice coverage or who are finding themselves involved in frivolous lawsuits, it may be quite a while before Congress will pass a meaningful reform bill. Until then, the state legislators and court justices will continue to have the most profound effect on the liability crisis.

Pennsylvania surgeons react

Most recently I participated in the Eastern Pennsylvania Chapter meeting. Access to affordable professional liability insurance and the tort system in Pennsylvania have been out of control for some time. In talking with our Fellows, I learned that they are being sued for minor and, indeed, frivolous reasons by very aggressive trial lawyers who are not appropriately regulated. Quite frankly, the numerous advertisements that appear in local newspapers and magazines and that are seen on television and heard on the radio give a good indication of how favorable the environment is for trial lawyers. As a result, all but one of the state's professional liability insurance carriers have exited the market, and there are very few physicians who are not involved in some form of litigation. The combination of these two factors has led to exorbitant malpractice insurance premiums in the state.

I am happy to report that the surgeons in



“I would like to think that if surgeons and the rest of the medical community can work together and with the public, we may be able to remedy the problems associated with lawsuit abuse and the malpractice insurance crisis before they prove catastrophic to our patients.”

Pennsylvania are not taking this situation lying down. They are pulling together and working to resolve the problem. For instance, the Eastern Pennsylvania Chapter is merging with the Central Pennsylvania Chapter to form a new Keystone Chapter of the American College of Surgeons. Potentially, chapters in the western portion of the state may be joining as well. The consolidation of the chapters will allow surgeons

in Pennsylvania to speak to these and other issues with a more unified voice. The officers of both the Eastern Pennsylvania and Central Pennsylvania Chapter are to be commended for their efforts, particularly the two Presidents at the time of the merger, Drs. Robert John Sinnott and Narayan Deshmukh, respectively.

In addition, the surgeons in this chapter and others throughout the state have been working with the Pennsylvania Medical Society (PaMS) to secure passage of professional liability reform legislation.

Mixed results

During this last legislative session, the Pennsylvania General Assembly passed and Gov. Mark Schweiker signed two liability reform laws. One piece of legislation, which was very recently enacted, limits the ability of plaintiffs and lawyers involved in malpractice lawsuits to file claims in or move trials to counties with a history of allowing large jury awards. Under this new law, cases may be filed only in a county where the cause of action occurred.

The other malpractice reform law enacted in Pennsylvania—the Medical Care Availability and Reduction of Error (MCARE) Act—includes a range of pros and cons. On the positive side, it modifies the collateral source rule, permits periodic payment of future damages for medical and related expenses, and imposes an absolute seven-year limitation on the time period for filing a lawsuit. However, the legislation excludes other necessary tort reforms, such as a cap on jury awards for noneconomic damages and limits on attorneys' contingency fees. It also contained one provision that physicians in the state adamantly oppose: the act replaces the state's existing excess liability fund with an MCARE fund. Physicians who are licensed and practice in the state must carry a minimum of \$500,000

in liability insurance in addition to the \$500,000 they must purchase through the MCARE fund. Needless to say, this mandate has become a real point of contention for physicians in Pennsylvania.

Next steps

Obviously, surgeons in Pennsylvania have a long road to travel before practicing in the state will again be tenable and before all the aftershocks of the crisis will be stabilized. For example, as a result of the environment in Pennsylvania, several obstetrical and trauma units have closed. Surgeons have been moving out of the state to practice elsewhere, and many surgeons I have spoken with are actually changing their practice patterns so that they may no longer be performing operations but simply following patients in their offices. Still other surgeons are retiring far earlier than they had expected to. It's going to take some time for these negative results to be reversed.

Even so, I was really impressed with how many surgeons in Pennsylvania are aggressively tackling the professional liability crisis. They are becoming much more proactive and are working together and with other physicians to promote meaningful tort reform. I believe this stance and unification of the medical community will allow for a more powerful advocacy effort on the part of the surgeons of Pennsylvania.

To help spread the word about their hard work and what they trying to accomplish, the Keystone Chapter plans to create an expanded Web site and to publish a newsletter in order to reach out to the various counties that have been incorporated into the newly formed chapter. In addition, the administrative support of the larger chapter will be effective in helping members to interact with legislators and to monitor the activities of the Pennsylvania Supreme Court,

which, in the past, has broadly applied its ability to overturn meaningful liability reform laws.

Power of patients

Of course, Pennsylvania is not the only state with a Supreme Court that has proven to be averse to legislation that limits the ability of trial lawyers to bring frivolous or inappropriate lawsuits against physicians. A recent editorial in the *Wall Street Journal* noted that tort claims in Mississippi “are so rampant that doctors are fleeing and 71 insurance companies have stopped writing policies in the state.” The editorial asserts that a Mississippi Supreme Court justice, whom voters denied the privilege of becoming chief of the court during last month’s elections, was a large part of the problem because his rulings had made the state “a honey pot for out-of-state trial lawyers.”

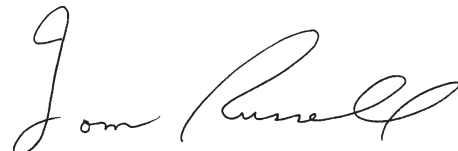
What this example demonstrates is that the American public is waking up to the problems associated with lawsuit abuse. I believe the citizens of the state of Pennsylvania and other hard-hit states will rapidly become more aware that it is becoming more difficult to receive appropriate care and that a major contributor to that problem is the fact that physicians simply can’t afford to buy malpractice insurance, which allows them to practice medicine. When the access situation reaches significant proportions, legislators will take the appropriate action and judges with biases toward the trial lawyers will lose their power.

Chapter involvement important

It is truly sad to think that our patients may be the ones to shoulder this burden before constructive steps toward solving the problem will be taken. However, I would like to think that if surgeons and the rest of the medical community can work together and with the public, we may

be able to remedy the problems associated with lawsuit abuse and the malpractice insurance crisis before they prove catastrophic to our patients.

Resolving surgeons’ concerns about liability and other issues in a productive way is precisely what the surgeons in Pennsylvania are trying to accomplish. Their efforts demonstrate the value of the College’s chapters, particularly as we attempt to address local issues through local engagement and activity. I would encourage other chapters to follow their lead.



Thomas R. Russell, MD, FACS

If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.

Dateline|Washington

prepared by the Division of Advocacy and Health Policy

CMS delays publication of 2003 fee schedule

On November 1, the statutory deadline for publishing final regulations to implement the 2003 Medicare physician fee schedule, the Centers for Medicare & Medicaid Services (CMS) issued a notice of delay in the *Federal Register*. According to the notice, the delay in issuing the fee schedule stems from concerns about data used to establish payments and the need to further assess the accuracy of the data.

Reportedly, the data in question pertain to new relative values that were calculated for anesthesia services. Concerns about the validity of the figures used to determine the fee schedule conversion factor were not addressed despite repeated attempts to call attention to the problem.

According to CMS sources, a 4.4 percent reduction in the conversion factor will still take place in 2003, since Congress failed to pass legislation before the end of the year to fix problems with the formula used to calculate the annual payment updates. However, implementation of the payment reduction will be delayed at least until February 1. At press time, publication of the final regulation was expected to occur in early December.

Republicans regain control of Congress

As a result of this year's congressional elections, Republicans regained control of the U.S. Senate and strengthened their hold on the House of Representatives. When the 108th Congress convenes in January, the Senate will consist of 51 Republicans, 47 Democrats, and one Independent. (The remaining seat will be filled following a December 2002 runoff election in Louisiana.) As chair of the National Republican Senatorial Committee, thoracic surgeon Bill Frist, MD, FACS (R-TN), oversaw this change in Senate party leadership, which is unprecedented in a midterm election.

The House will be composed of 228 Republicans, 206 Democrats, and one Independent, representing a net gain of four seats for the Republicans. Rep. Dennis Hastert (R-IL) is expected to retain his post as Speaker of the House. However, Rep. Richard Gephardt (D-MO) stepped down as Minority Leader immediately after the election.

The congressional committees with health care jurisdiction will have new Senate committee chairs, while the House committee chairs are expected to remain the same. The Senate Finance Committee, which has jurisdiction over the Medicare program, will be chaired by Sen. Charles Grassley (R-IA), while the Health, Education, Labor and Pensions Committee will be chaired by Sen. Judd Gregg (R-NH). Reps. Bill Thomas (R-CA) and Billy Tauzin (R-LA) are expected to remain as chairs of the House Ways and Means Committee and House Energy and Commerce Committee, respectively.

Finally, two physicians have been newly elected to the House. Obstetrician-gynecologists Phil Gingrey, MD (R-GA), and Michael Burgess, MD (R-TX), were successful in their bids to represent new districts. Unfortunately, two House members who are Fellows of the College—plastic surgeon Greg Ganske, MD, FACS (R-IA), and ophthalmologist John Cooksey, MD, FACS (R-LA)—were unsuccessful in their efforts to unseat incumbent senators.

IOM to release next study on medical errors

In late October, the Institute of Medicine (IOM) of the National Academy of Sciences announced the release of a draft report, *Leadership by Example: Coordinating Government Roles in Improving Health Care Quality*. This will be the third in a series of IOM reports on the quality and safety of health care in the U.S.

After examining the quality enhancement process in six federal programs, the IOM is suggesting that the federal government establish standard measures of quality, assess the performance of individual health care providers, and publish comparative data for consumer use. Moreover, the IOM is proposing that the federal government link pay to performance as a means of encouraging exemplary levels of performance.

Copies of the report will be available this winter from the National Academies Press. Meanwhile, the manuscript can be viewed on the Web at <http://www4.nationalacademies.org/news.nsf/isbn/0309086163?OpenDocument>.

Justice department announces health antitrust hearings

The Department of Justice announced November 7 that its Antitrust Division will hold hearings on health care competition law and policy beginning in February 2003. The hearings, to be cohosted with the Federal Trade Commission (FTC), will be only the second set ever held by the Antitrust Division. The first hearings took place earlier this year and centered on the relationship of antitrust law and intellectual property law. Those hearings were cohosted with the FTC.

Topics expected to be covered include hospital mergers, the significance of hospitals' not-for-profit status, vertical arrangements, quality and efficiency, and the adequacy of existing remedies for anticompetitive conduct. With respect to health plans, information will be sought on such questions as whether plan consolidation is likely to give rise to market power, whether plans coordinate either tacitly or explicitly in ways that raise antitrust concerns, the costs of and impediments to entry into health plan markets, and the conditions under which plans might obtain and exercise monopsony power against providers.

The specific dates and topics of the hearings will be published in the *Federal Register*. It is anticipated that a public report based on the presentations made and submissions received during the hearings will be prepared at the conclusion of the hearings.

Medicaid enrollment growth rate doubled in 2001

Medicaid enrollment rose 3.3 million from December 2000 to December 2001, according to a survey released by the Kaiser Commission on Medicaid and the Uninsured. The 2001 enrollment growth rate of 9.8 percent exactly doubled the 4.9 percent growth rate in 2000.

For families, children, and pregnant women, the rate of growth increased from 7 percent in 2000 to 14.1 percent in 2001. This increase was driven by two opposing trends—welfare reform on the one hand, and efforts to expand enrollment in the State Children's Health Insurance Program on the other. The rate of enrollment growth for the aged and disabled in Medicaid, a generally more costly category of enrollees, was 3 percent in 2001, compared to 2.2 percent in 2000. The entire report may be found at <http://www.kff.org/content/2002/4067>.



Presidential Address

**The challenge
of emerging
surgical technology:
The College can help**

**by Richard R. Sabo, MD, FACS,
Bozeman, MT**

Editor's note: Following is the edited text of the Presidential Address that Richard R. Sabo, MD, FACS, delivered during the Convocation at the 2002 Clinical Congress.

C. James Carrico, MD, FACS, died July 25. One year ago, he was chosen to become President of this College, an honor richly deserved and thoroughly appreciated. He wrote to the College in May, saying, "I have received no greater honor in my surgical career than being elected to serve as President of the American College of Surgeons."

I miss him. The College misses him. The whole world of surgery will miss him. I wish he were here to give this address, to share his wisdom, and to lead the College during the coming year. Although he can't talk to us tonight, his life speaks volumes about the highest ideals of a skilled and caring surgeon, a passionate educator, a distinguished scholar, and a true gentleman.

I am a general surgeon who practices in a community hospital in Bozeman, MT. Previous Presidents of the College have called upon their special expertise in surgery or unique world view to share on this occasion. My perspective is that of a practicing community surgeon whose professional life has been extremely rewarding. I have thoroughly enjoyed taking care of patients, enjoyed the friendship and support of my colleagues, and, for more than half of my career, enjoyed a rich association with the American College of Surgeons.

In this address, I'd like to share with you some of the challenges I have faced in my career. I'm going to talk about the problems of incorporating new technology into practice and how the College can help. Some of those problems are unique to a small community practice, but most are faced by all surgeons. I'm sure

you'll find yourselves dealing with them during the course of your career. In discussing these challenges, it will become obvious how much Dr. Carrico and his associates on the Committee on Emerging Surgical Technology and Education (CESTE) have done to help us all.

How things have changed

When I began my career in 1971, the practice of surgery was profoundly different. Radical mastectomy was done for most women with breast cancer regardless of the size or stage of the disease. Gastric surgery was common for the treatment of peptic ulcer disease. There were no surgical staplers or flexible endoscopes, and the thought of doing intraabdominal surgery with a laparoscope would have been incomprehensible.

How things have changed. Like most surgeons, my professional life has been characterized by continual change: changes in the concepts of disease, changes in the techniques of surgery, changes in the environment in which we practice, and changes in the expectations of patients.

Lawrence Way, MD, FACS, recently reported the results of a survey in which he asked 80 colleagues to name the major advances that have occurred in general surgery during the last 25 years.¹ The majority of respondents agreed that the most profound changes have been the better understanding and control of nutrition, improvements in critical care, the advent of fiber-optic endoscopy, and the introduction of laparoscopic surgery. When asked about major advances in the future, they predicted that the trend of less invasive surgery will continue as devices become smaller and even more sophisticated. They also predicted that new discoveries in molecular biology and genetics will result in dramatic therapeutic advances, especially in the treatment of malignant disease.

Changes such as these create much of the excitement and stimulation of surgical practice—the challenge to keep up with new ideas and the joy of learning and perfecting new skills. However, change may also produce stress and frustration because of the uncertainty that inevitably is associated with the transition from old to new ideas. That holds true whether you are a solo practitioner in rural Montana or an academic surgeon in the center of Boston, MA.

In the recent best-selling book, *Complications: A Surgeons' Notes on an Imperfect Science*, Atul Gawande, MD, characterized our profession in this way: "As a doctor, you come to find that the struggle in caring for people is more often with what you do not know than what you do. Medicine's ground state is uncertainty. And wisdom for both patients and doctors is defined by how one copes with it."²

Conceptual changes may be particularly difficult to diffuse into practice. Breast conservation surgery was shown to be equivalent to mastectomy in at least three randomized controlled trials published between 1981 and 1989.³⁻⁵ Because of the slow adoption of the procedure into practice, a 1992 national consensus conference was convened and concluded that breast conservation was appropriate for most women with early primary carcinoma of the breast.⁶ Five years later, 14 years after the results of the first trial became known, only 40 to 60 percent of eligible women received conservative surgery.⁷ It is clear from this example that many physicians had difficulty giving up traditional therapy and incorporating a new concept of disease and treatment into their thinking.

In contrast, laparoscopic cholecystectomy took the surgical world by storm. In less than two years, it replaced open cholecystectomy as the standard procedure for removing the gallbladder. That transition was chaotic, with extreme variability in the way it was introduced. Many patients suffered unnecessary complications and there were even some deaths because of inadequately trained surgeons.

Occurrences like these suggest that intuition, personal experience, physiologic reasoning, and tradition are inadequate guides for important clinical decisions.

CESTE

Dr. Carrico became a Regent of the College in 1992, shortly after the adverse results of the laparoscopic cholecystectomy transition were recognized. The College responded by creating CESTE with Dr. Carrico as its chair. He, Jonathan Meakins, MD, FACS, who is the current chair, and the other dedicated Fellows on the committee spent the next decade analyzing the implications of new surgical technology. The fruits of their la-

bor are five official "Statements" of the College that were published between 1993 and 2000 and are available on the College's Web site (www.facs.org).

The first one, "Statement on Laparoscopic and Thoracoscopic Procedures," defines who should do minimally invasive procedures and outlines the general qualifications a surgeon should possess before doing these procedures.

The "Statement on Emerging Surgical Technologies and the Evaluation of Credentials" recognizes that the introduction of any new technology should proceed through a series of steps that ensure its safety, appropriateness, and cost-effectiveness. The process needs to be balanced and should not be so stringent that it unreasonably delays the development of an innovative procedure. On the other hand, the safety of the procedure must be established before it is widely disseminated into practice. The statement outlines three key steps. First, a procedure must have a strong evidence base, ideally from controlled clinical trials. Second, its diffusion into practice must be accomplished through appropriate education and training. Finally, the results of the new technique must be continuously monitored. This statement also provides guidelines for the evaluation of credentials before privileges for a surgical procedure are awarded.

The "Statement on Issues to Be Considered Before New Surgical Technology Is Applied to the Care of Patients" poses four questions that surgeons and institutions should ask about a new procedure: (1) Has it been tested adequately? (2) Is it cost-effective? and (3) Is the surgeon fully qualified? (4) Is it at least as safe as current techniques? There is enormous public pressure to reduce the invasiveness of procedures by using minimal-access techniques; however, these techniques may be less effective than their standard counterparts and might result in more complications.

The next statement from CESTE, "Approval of Courses in New Skills," defines standards for courses in new technology. Most new procedures are learned informally through commercial courses offered by experts or industry representatives, through mini-preceptorships, or simply through observation of surgeons who have begun to use the techniques. This sort of learning is irregular at best, and tends to focus only on the tech-

nique and not on the theoretical basis on which the technique is founded. By defining standards for courses, the committee provides a mechanism for surgeons to choose courses that will meet their needs and for institutions to know that a surgeon applying for privileges has the expected level of knowledge and skills.

The final statement from the committee, "Verification by the American College of Surgeons for the Use of Emerging Technologies," describes a method by which a Fellow could be verified by the College for the use of a new technology. The process would provide the surgeon with documentation sufficient to persuade the credentialing committee to grant privileges.

Room for improvement

These statements provide an extremely helpful guide for surgeons introducing new technology into practice. However, the statements are less helpful in determining which procedures to select or when to select them.

Typically, a new procedure is introduced as a case report or series of favorable cases from a single institution. Confirmation from other institutions adds to its visibility and this technique might then become the topic of a panel discussion at national meetings. If the panel experts are using it in their own practices, surgeons in the audience are motivated to begin using it. The impetus becomes stronger if organizations such as the College offer training courses on the procedure. Ultimately, there may be a consensus conference or randomized controlled trials defining this method as the standard of care. Somewhere along this increasingly convincing stream of data, a surgeon may decide to incorporate the new procedure into his or her practice. If this method is a minor modification of existing techniques, the change is not difficult. However, if it involves a complex procedure or a significant conceptual change, the challenge becomes more difficult.

The point of decision will vary among surgeons. An academic surgeon in a high-volume tertiary care center will have a significantly different threshold than a rural surgeon in solo practice. Community surgeons must first ask if they will have the volume of patients necessary to acquire the skills and maintain their proficiency. What

“Occurrences suggest that intuition, personal experience, physiologic reasoning, and tradition are inadequate guides for important clinical decisions.”

supporting resources does their hospital provide? Can unexpected complications that might arise from the procedure be addressed adequately?

There is enormous pressure on surgeons to provide the latest technology and appear to be on the cutting edge. Patients are constantly bombarded with information about new techniques in the lay press—information that quite often is selected for its sensationalism more than its accuracy. Today's patients have access to much more medical information than their predecessors did; unfortunately, much of it is misinformation. They want the least invasive procedure available, and they expect a good outcome. If their surgeon can't provide the latest technique or offer a reasonable explanation for not making it available, patients will look elsewhere.

Surgeons tend to be risk-takers. They enjoy learning new procedures and pride themselves on their technical abilities. There are more pressures to adopt a new procedure than there are restraints to wait for solid evidence of its safety and efficacy. Where is the decision threshold? What is the trigger that tips the scale for a surgeon so he or she will sign up for a course and begin the training process? Surgeons, especially those of us who practice away from academic medical centers, are looking for guidance and the College can do much to help us.

The CESTE statements repeatedly call for an examination of the evidence supporting a new procedure. This may be the most difficult part of the evaluation process. Unbiased information is difficult to find. When we review the literature there is a tendency to select articles that suit our own point of view and fit into preconceived ideas. Information from industry is designed to sell products more than to educate surgeons. Suggestions from colleagues may or may not be based on facts.

Evidence-based medicine

In 1990, a new philosophy of medical practice was developed at McMaster's University in Alberta, Canada. It emphasized that each clinical decision should be based on knowledge and understanding of the medical literature. This philosophy became known as evidence-based medicine (EBM), a term defined as follows in an internal document for medical residents:

"Residents are taught to develop an attitude of 'enlightened skepticism....' The goal is to be aware of the evidence on which one's practice is based, the soundness of the evidence, and the strength of inference the evidence permits."⁸

Evidence-based medicine also suggests that there is a formal set of rules that complements training and common sense when clinicians interpret the results of clinical research.

The details of this philosophy are spelled out in a series of articles published in the *Journal of the American Medical Association* starting in 1993 and culminating in the recent publication of the *Users' Guides to the Medical Literature: A Manual for Evidence-Based Clinical Practice*.⁸ It outlines basic skills for evaluating the literature that every practicing physician should have. Since its con-

ception the process has evolved, especially with regard to its application to surgery.

Using the strict criteria of evidence-based medicine to evaluate surgical procedures has been frustrating. In 1997, the Royal Australasian College of Surgery established a pilot project to provide an evidence base to support the introduction of new procedures into surgery. It's called ASERNIP-S, which is the acronym for the Australian Safety and Efficacy Register of New Interventional Procedures—Surgical, and its Web site is located at <http://www.surgeons.org/open/asernip-s.htm>. The Royal College developed a process to comprehensively review all relevant literature about a new procedure and to assign it to one of three categories: (1) the procedure is safe and efficacious; (2) it is unsafe; or (3) there is insufficient data to determine its safety and efficacy. Of the first 16 procedures reviewed, all but two fell into the undetermined category. There may be less scientific basis for our surgical practices than we would like to admit. Using classical rules of evidence on surgical procedures has not been productive.

Dr. Meakins, former Vice-Chair of the Board of Regents and current chair of CESTE, has written extensively on changes in technology and the usefulness of evidence-based medicine in surgery.⁹ He makes a strong case for modifying the rules of evidence for surgical procedures and for including carefully controlled observational studies in their evaluation. He summarizes the five steps involved in the practice of EBM: (1) define the question or problem; (2) search for the evidence; (3) critically appraise the literature; (4) apply the results; and (5) audit the outcome.¹⁰

Dr. Meakins and his colleagues at McGill University Health Center in Montreal, PQ, have done this. They have set up a diverse committee that routinely scans the horizon for potentially significant new data and new procedures. The members of the committee critically evaluate the data, assess its applicability, make a decision to incorporate the new procedure into their group practice, and have a refined process to ensure that all surgeons offering the new procedure are adequately trained and proctored. Performance is monitored and all outcomes are recorded. This process is a model for assessing new technology that all of us could emulate.

However, most practicing surgeons don't have the time, skill, or resources to do systematic reviews of the original literature. There were over 2,000 surgically related randomized controlled trials published last year. Fortunately, preassessed critical reviews and published practice guidelines are becoming increasingly available. The *British Journal of Surgery* has a section specifically directed to critical appraisal, entitled "Systematic Reviews." The October issue of the *Journal of the American College of Surgeons* introduced a new section called "Evidence-Based Surgery," which will be a regular feature of the journal.

Several collections of critical reviews are also available on the Internet: Here are some examples of their home pages:

- The Cochrane Library, www.cochrane.library.com
- National Guideline Clearinghouse, www.guideline.gov
- Cancer Care Ontario's Program in Evidence-Based Care, www.ccopebc.ca.

Future steps

The College has an opportunity to use its communications resources, like our electronic newsletter *ACS NewsScope*, to quickly disseminate information on significant new critical reviews and practice guidelines.

An exciting development at the College is a project headed by Alden Harken, MD, FACS, a Regent, called the American College of Surgeons Safety and Efficacy of Innovative Procedures and Technology in Surgery. Although similar to the ASERNIP-S program of the Royal Australasian College of Surgery, it uses recently developed data-review strategies and creates additional categories that include a place for surgical procedures that may be recommended but that have not yet reached the level of standard of care.¹¹ A recommendation of this type might be just the information surgeons considering a procedure for their practice might need.

Once a surgeon makes a decision to learn a new technique or procedure, his or her training must be adequate. Surgeons need to choose courses that incorporate well-defined objectives, clear structure, and thorough evaluation. The College needs to develop mechanisms to verify

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that the courses in new technology meet these standards.

The final step in the process of incorporating new technology into practice is proctoring the procedure. There is a learning curve for any new technique. In other words, complications are more frequent during a surgeon's first few procedures. For example, a 1995 study of 55 surgeons who performed more than 8,000 laparoscopic cholecystectomies showed that 90 percent of the injuries occurred within a surgeon's first 30 cases.¹² Thus, it is mandatory that the surgeon is as high on the learning curve as reasonably possible before he or she operates independently. Proctors provide the necessary bridge between a surgeon's technical training and his independent performance of a new procedure. Their role includes super-

vision, teaching, role modeling, and evaluation. Many surgeons have difficulty finding suitable proctors. The College needs to facilitate this necessary link by encouraging experienced surgeons to offer their services and by assisting surgeons in locating proctors. In rural areas, the College might consider setting up regional preceptor programs and providing proctors with assistance and guidelines.

Evolving theories of adult education will result in more efficient techniques of teaching, methods that will ensure changes in physicians' performance. The College needs to develop new ways to teach surgeons by using skill laboratories, surgical simulators, and eventually distance learning techniques using high-speed Internet communications. Surgeons will need to discover new sources of information and adapt to new ways of learning.

Let me leave you with a final thought. All of you in the class of 2002 will be faced with continual changes in your practice and will confront the challenges of incorporating new technology into the work that you do. Dr. Carrico left us all with a legacy both by example and through the work of CESTE. Ultimately, the responsibility of wisely incorporating new technology into your daily practice lies in the principles you have sworn to uphold as a Fellow of the College and will depend on your integrity, your commitment to lifelong learning, your professionalism, and your desire to put the welfare of your patients above all other considerations. □

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Economic credentialing:

A growing concern



by

Jon H. Sutton,
*State Affairs Associate,
Division of Advocacy and Health Policy*

Every day surgeons face a number of outside pressures as they work to provide comprehensive and quality care to their patients. Multiple managed care contracts, volumes of government regulations, and the competitive marketplace all contribute to the complexity of maintaining a surgical practice.

As surgeons continue to invest in ambulatory surgical centers and single-specialty hospitals, they are finding themselves more frequently in direct competition with community and teaching hospitals. The following article examines how hospitals are increasingly using the tool of “economic credentialing” to pressure surgeons into steering more care toward the hospital setting.

What, exactly, is it?

Economic credentialing is “the use of economic criteria unrelated to quality of care or professional competency in determining an individual’s qualifications for initial or continuing hospital medical staff membership or privileges.”¹

In the past, economic credentialing was more centered on inpatient volume, with hospitals refusing to recredential surgeons who failed to bring enough business into the hospital. Hospitals commonly used this tool in situations where the surgeon may have had privileges at multiple hospitals that were competitors. Today, economic credentialing is just as likely to occur when a surgeon or group of surgeons builds an outpatient surgical facility or single-

specialty hospital that is in direct competition with the hospital.

Causes

The exploding growth of ambulatory surgery centers and single-specialty surgical outpatient facilities—coupled with advances in technology that have made these venues safe alternatives to the inpatient setting—have resulted in an increasing number of procedures being shifted out of the confines of the hospital. Surgeons are financing these centers both to gain greater control over patient care and to establish an additional revenue source during a time when reimbursement for inpatient procedures is declining.²

With surgeons moving many outpatient procedures from the hospital setting to ambulatory surgical facilities, hospitals are experiencing decreased outpatient volume and, in turn, loss of revenue.³ Hospitals have responded to this competition through restrictive medical privileges. However, hospital boards realize they must be careful in their use of economic criteria when denying or approving medical staff privileges to avoid triggering an antitrust/restraint of trade investigation. Hence, hospitals may deny medical staff privileges based on quality concerns or because they feel there are too many physicians of the same specialty in their geographic region.

Approaches

One approach to economic credentialing that some hospitals are using involves signing exclusive contracts with surgical groups as a competitive response to the ambulatory surgical facility and then denying staff privileges to members of the surgical group who own the facility. For example, a lawsuit filed during the mid-1990s in South Dakota illustrates how economic credentialing and exclusive contracts may be applied in a competitive situation.

Avera St. Luke's Hospital, located in Aberdeen, lost its neurosurgeon in 1996. The hospital board wanted to recruit another neurosurgeon and passed a resolution to recruit two neurosurgeons or two spine-trained orthopaedic surgeons. However, as part of the recruitment process, the hospital board discovered that most neurosurgeon applicants had little interest in coming to Aberdeen if an orthopaedic spine surgeon already was prac-

ticing in the area, because the neurosurgeon would need to perform back and spine surgeries to supplement the practice.

The hospital successfully recruited a neurosurgeon in December 1996, but learned at the same time that a group called Orthopaedic Surgery Specialists (OSS) was planning to build an ambulatory surgery center that would compete with the hospital. In the first seven months of the surgery center's operation, the hospital lost 1,000 hours of operating room use because the surgeons in OSS moved their procedures from the hospital to the surgery center. In June 1997, the hospital board passed a resolution to close the hospital's medical staff to physicians requesting privileges for three spinal procedures—spinal fusions, closed fractures of the spine, and laminectomies. It also closed the medical staff to applicants for orthopaedic surgery privileges except for two general orthopaedic surgeons being recruited by the hospital. Existing privileges for surgeons on the medical staff, including those from OSS, were not affected.

OSS then recruited another surgeon for the practice, who applied for and was denied privileges at the hospital. OSS filed a lawsuit claiming the hospital board was in breach of contract by violating the powers and rights of the medical staff bylaws and the medical staff to which it had delegated significant powers for staff privileging. The circuit court agreed with OSS.

The hospital appealed to the South Dakota Supreme Court, which disagreed with the ruling of the circuit court. The South Dakota Supreme Court ruled that the hospital board is the decision maker when it comes to granting privileges, and the medical staff is only responsible for reviewing applications to evaluate the professional competence of applicants and for making recommendations to the hospital board. In addition, the court said the hospital has the right *based on economic reasons* to close the medical staff to additional physicians and surgeons not only by specialty, but also by procedure. It noted this is not different from granting exclusive contracts to certain physician groups (which the hospital had done in the past for radiology, laboratory/pathology, and so on).⁴

Exclusive credentialing, under which granting of privileges is conditioned upon the surgeon be-

ing exclusive to that hospital and not having membership or privileges at any other hospital, is another way that a hospital may respond to competition. In a sense, it is similar to exclusive contracting, except it applies to an individual physician and not to a specialty group. Regardless, the effect is the same—competition is restricted, and access to specialty care in smaller communities with limited numbers of hospitals may be compromised.

Limiting use

How can the use of economic factors be limited in the area of credentialing and privileging? Passing state legislation is one method, but a less complex process would be modifying the medical staff bylaws. Possible bylaws language could include:

Medical staff membership and privileges may be granted, continued, modified, or terminated by the Board only upon recommendation of the medical executive committee for reasons directly related to quality of patient care and other provisions of the medical staff bylaws. Under no circumstances shall economic criteria unrelated to quality of care be used to determine qualification for initial or continuing medical staff membership or privileges.⁵

Revising medical staff bylaws must be done according to procedures spelled out in the current bylaws. The process may be time-consuming, but it is certainly worth the effort if appropriate language is adopted.

When it comes to building an ambulatory surgery center or a single-specialty hospital, surgeons could consider a joint venture with the hospital. The positives of this arrangement are that the hospital and the surgeons would not be in competition with each other, obtaining state approval for the facility would be a shared task, and risk would be shared by both groups. The downsides are that surgeons might not have the degree of independence they want, and a revenue sharing agreement would be part of the venture. □

Surgeons seeking information or assistance with state-level legislative or regulatory issues should contact Christopher Gallagher, Manager of State Affairs in the College's Washington Office at 202/337-2701

(cgallagher@facs.org), or Jon Sutton, State Affairs Associate, in the College's Chicago office at 312/202-5358 (jsutton@facs.org).

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Clinical Congress 2002



Highlights

Approximately 15,400 surgeons, other physicians, exhibitors, guests, and convention personnel participated in the 2002 Clinical Congress October 6-11 in San Francisco, CA. The 88th annual meeting of the American College of Surgeons provided participants with the usual forum for learning about the art and science of surgery, as well as the opportunity to witness the initiation of some significant modifications to the program.

A distinguished group of speakers from a range of nations presented the nine named lectures. Additional educational highlights of the meeting included sessions on the use of robots in the operating room, the design of morbidity and mortality conferences, the ethics of entrepreneurialism, patient safety, the influence of heroes on surgical careers, and computerized image-guided neurosurgery.

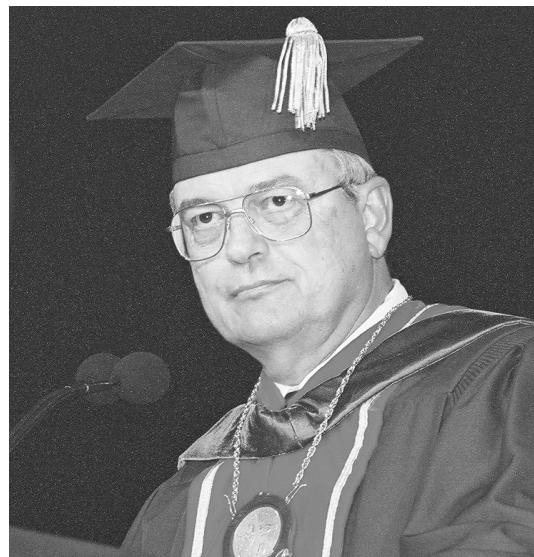
Among the changes instituted at this year's Clinical Congress was the elimination of one day of sessions. This reduction in the program's duration allowed surgeons to return expeditiously to their busy practices.

Additionally, the Opening Ceremony and the American Urological Association (AUA) Lecture were combined as the kickoff presentation of this year's Congress. The session began with the Opening Ceremony, Introduction of Dignitaries and Special Invited Guests. Then-President **R. Scott Jones, MD, FACS**, served as the presiding officer. Dr. Jones also introduced this year's AUA Lecturer, **Haile T. Debas, MD, FACS**, who spoke on Medicine in the Twenty-First Century.

Another new event at this year's Clinical Congress was a post-Convocation reception for the Initiates. The purpose of this gathering was to allow the new Fellows to meet and network with the College's leadership.

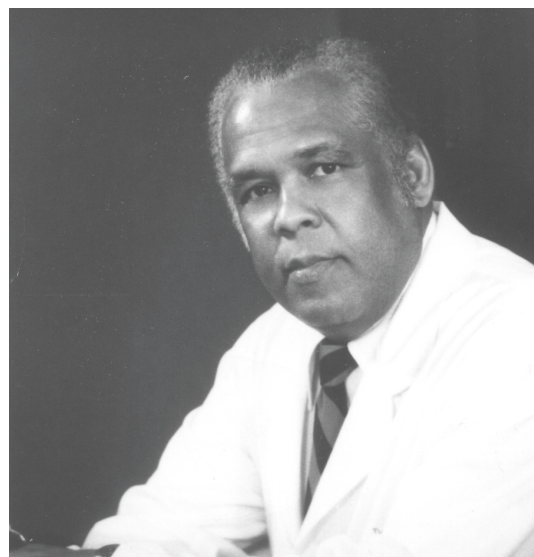
Other noteworthy moments were reported in the

Facing page: Scenes from the 2002 Clinical Congress. Clockwise from upper left: Dr. Jones presents Dr. Sabo with the Presidential Medallion; an Associate Fellow tries out new technology in the technical exhibit area; Dr. John O. Gage, ACS Secretary, with the Great Mace at the Convocation; 2002 DSA recipient Dr. Blaisdell; participants in a postgraduate course on personal data assistants; Initiates reciting the Fellowship Pledge during the Convocation. (All photos by Chuck Giorno Photography.)



CHUCK GIORNO PHOTOGRAPHY

Dr. Sabo during his Presidential Address.



Dr. Organ, President-Elect.

November *Bulletin*, including the presentation of the Distinguished Service Award to **F. William Blaisdell, MD, FACS** (see photo, p. 21). The November issue also contained information regarding the four surgeons who were awarded Honor-

ary Fellowship in the College: **Alan C. Bird, MD, FRCS (Eng)**; **Juan Carlos Parodi, MD**; **Graham M. Teasdale, FRCS (Edin, Glas), FRCP (Lon)**; and **Sir Magdi H. Yacoub, FRS, FRCS (Eng, Ed, Glas)**.

Following are some other high points of the Clinical Congress.

Officers installed

Richard R. Sabo, MD, FACS, a private practice general surgeon from Bozeman, MT, was installed as the 83rd President of the American College of Surgeons during the Convocation ceremonies. Dr. Sabo is a staff surgeon at Bozeman Deaconess Hospital. In the past, he has served as an adjunct professor in the department of medical science at Montana State University-Bozeman.

Dr. Sabo's Presidential Address focused on the continuing advancements in surgical technology, stressing the importance of organizations such as the ACS in providing adequate training in their safe and effective use. Dr. Sabo noted that the College created the Committee on Emerging Surgical Technology and Education (CESTE) in response to growing concerns about the difficult transition from open to laparoscopic cholecystectomy. Similar challenges are likely to become more prevalent over the coming years, he added, suggesting means by which the College may prepare surgeons for them. (The text of Dr. Sabo's speech appears on page 8.)

Additionally, **Amilu S. Rothhammer, MD, FACS**, was installed as Second Vice-President. Dr. Rothhammer is a general surgeon in private practice and is on staff at Penrose Hospital in Colorado Springs, CO. She is a member of the College's Development Committee and served as Secretary (1996-1998) and Chair (1998-1999) of the Board of Governors.

New officials

Claude H. Organ, Jr., MD, FACS, FRACS, was named ACS President-Elect during the Annual Meeting of Fellows and Initiates. Dr. Organ is a professor in the department of surgery at the University of California, San Francisco-East Bay, and chair of the university's surgical residency program.

Since becoming a Fellow of the College in 1961, Dr. Organ has served the organization in numer-

ous capacities. He has been a member of the Commission on Cancer since 1979, a member of the College's International Relations Committee since 1995, and Vice-Chair of the Committee on Motion Pictures (1977-1978). A renowned surgical educator, Dr. Organ has presented the College's Opening Ceremony Lecture on two occasions—in 1987 and 1995. At the local level, he has served as a member of the Credentials Committee of the Nebraska and Oklahoma Chapters and as a member of the Executive Committee of the Northern California Chapter. In 1999, the Board of Regents named him the recipient of the College's highest honor—the Distinguished Service Award. Dr. Organ was the College's Second Vice-President from 2001 to 2002.

A 1952 graduate of Creighton University School of Medicine, Omaha, NE, Dr. Organ served in the U.S. Naval Reserves as Lieutenant Commander MC and director of dependent surgery services at the U.S. Naval Hospital at Camp Pendleton, CA, from 1957 to 1959.

From 1960 to 1982, Dr. Organ worked his way up from instructor to chairman in the department of surgery at Creighton University. In 1982, he went on to serve as a professor of surgery at the University of Oklahoma Health Sciences Center, Tulsa. From 1988 to 2001, Dr. Organ was a professor in the department of surgery and chair of the surgical residency program at the University of California, Davis-East Bay.

Dr. Organ has held many leadership positions at other surgical organizations. He served as chairman of the American Board of Surgery (1984-1986); president of the Southeastern Surgical Congress (1984-1985); and president of the Society of Black Academic Surgeons (1995-1996). He also served as a member of the Residency Review Committee for Surgery and the National Board of Medical Examiners Surgery Test Committee.

In addition, Dr. Organ has served as the editor of the *Archives of Surgery* and as a member of the editorial boards of a number of other journals, including the *Australia and New Zealand Journal of Surgery*, *Asian Journal of Surgery*, *Journal of the American Medical Association (JAMA)*, *Oncology Times*, and *The Pharos*. He has presented many lectures on a range of topics and a lecture has been created in his name—the Annual Claude H. Organ, Jr., Lecture of the Southwestern Surgical Congress.



CHUCK GIORNO PHOTOGRAPHY

During the annual meeting, Dr. Blaisdell (left) was presented with the 2002 Distinguished Service Award by Dr. Jones.



CHUCK GIORNO PHOTOGRAPHY

Dr. Buchwald (left) received a Steuben glass bowl presented by Dr. Mentzer to commemorate the dedication of the *Owen W. Wangenstein Surgical Forum* to Dr. Buchwald.

The author of more than 250 scientific articles and book chapters, Dr. Organ's professional interests are in general and endocrine surgery. He is the author or coauthor of five books, including the two-volume set, *A Century of Black Surgeons: The U.S.A. Experience* (1987), and *Abdominal Access in Open and Laparoscopic Surgery* (1996).

Furthermore, Dr. Organ has made admirable contributions to many civic and educational institutions, including serving on the board of directors of Boystown, Inc., serving as a president of the Urban Housing Foundation, and serving as a trustee for Meharry Medical College, Nashville, TN, and Howard University, Washington, DC.

In addition, the Fellows named **Anna M. Ledgerwood, MD, FACS**, as First Vice-Presi-

dent-Elect, and **Murray F. Brennan, MD, FACS**, New York, NY, as Second Vice-President-Elect.

Dr. Ledgerwood is a general surgeon and professor of surgery at Wayne State University, Detroit, MI. A Fellow since 1975, Dr. Ledgerwood served on the Committee on Trauma (1980-1990), the Nominating Committee of the Board of Governors (1998-2000), and the Committee on Women's Issues (2001-present). She presented the 1996 Scudder Oration on Trauma.

Dr. Brennan is a general surgeon and chairman, department of surgery, Memorial Sloan-Kettering Cancer Center, New York, NY. A Fellow since 1977, he has served as a member of the Commission on Cancer since 1989 (Executive Committee, 1990-

1995), a member of the Fellows Leadership Society since 1995, and as Vice-Chair of the International Relations Committee since 1997. Dr. Brennan was the recipient of the 2000 ACS Distinguished Service Award.

Board of Regents

In other College business during the Clinical Congress, the ACS Board of Governors elected **Charles D. Mabry, MD, FACS**; **Robin S. McLeod, MD, FACS**; and **Carlos A. Pellegrini, MD, FACS**, as Regents of the College.

Dr. Mabry is a general surgeon in private practice in Pine Bluff, AR. He is also an associate clinical professor of surgery, department of surgery, University of Arkansas for Medical Services, Little Rock. He has served as President of the Arkansas State Chapter and as a member of the Committee on Young Surgeons (1989-1995) and has been a member of the General Surgery Coding and Reimbursement Committee since its inception. Dr. Mabry also served on the Regents' Communications Committee (1991-1995) and has been an ACS representative to the American Medical Association (AMA) Relative Value Update Committee for several years. He currently serves on the AMA Concurrent Coding Initiative Committee and as an Editorial Advisor for the *Bulletin*. He has been a Fellow since 1984 and will serve an initial three-year term as Regent.

Dr. McLeod is a colorectal surgeon affiliated with Mt. Sinai Hospital in Toronto, ON. She is Chair of the Governors' Committee on Surgical Practice in Hospitals and has served on that committee since 1999. She is Vice-Chair of the Surgical Research Committee for the Forum on Fundamental Surgical Problems (2000-2002). Dr. McLeod has been a Fellow since 1990 and will serve an initial three-year term as Regent.

Dr. Pellegrini is a general surgeon and The Henry N. Harkins Professor and chairman, department of surgery, University of Washington, Seattle. He has served as President of the Northern California Chapter of the College (1990-1991) and as a member of the Committee on Medical Motion Pictures (1988-1994, Chair 1993-1994). He served as senior member of the International Relations Committee from 1983 to 1993. Dr. Pellegrini has been a Fellow since



CHUCK GIORNO PHOTOGRAPHY

Dr. Bender (left) presented the Distinguished Philanthropist Award to Dr. and Mrs. Berry.



CHUCK GIORNO PHOTOGRAPHY

The 2002 National Safety Council's Surgeons Award for Service to Safety was presented to Dr. Aprahamian (center) by Dr. Meredith (left), and Dr. Hoyt.

1982 and will serve an initial three-year term as Regent.

Reelected to an additional three-year term on the Board of Regents was **Alden H. Harken, MD, FACS**.



CHUCK GIORNO PHOTOGRAPHY

Recipients of the College's Distinguished Service Award gathered during the Congress for their annual luncheon. Pictured with their hosts, front row (left to right): Murray F. Brennan; LaMar S. McGinnis, Jr.; Seymour I. Schwartz; James C. Thompson; Vallee L. Willman; Josef E. Fischer; and host Richard R. Sabo, 2002-2003 ACS President.

Second row: Luncheon host J. Patrick O'Leary, Chair of the Board of Governors Executive Committee (B/G E/C); host Sylvia D. Campbell, Vice-Chair of the B/G E/C; Frank Padberg; C. Thomas Thompson; John O. Gage; and host Timothy C. Fabian, B/G E/C Secretary.

Back row: David L. Nahrwold; C. Barber Mueller; and Claude H. Organ, Jr.



CHUCK GIORNO PHOTOGRAPHY

The Past-Presidents of the College met during the Congress for their annual luncheon. Picture, front row (left to right): Henry T. Bahnson; G. Tom Shires; C. Rollins Hanlon; W. Gerald Austen; George F. Sheldon; James C. Thompson; and Oliver H. Beahrs. Back row: M. J. Jurkiewicz; Seymour I. Schwartz; LaSalle D. Leffall, Jr.; Harvey W. Bender, Jr.; Lloyd D. MacLean; Frank C. Spencer; and Thomas R. Russell, ACS Executive Director.



CHUCK GIORNO PHOTOGRAPHY

The 2002 International Guest Scholars and International Relations Committee members gathered during the Congress. Pictured front row (left to right): Dr. Naone; Dr. Roxas; Dr. Maldonado; Dr. Abbas; and Keith A. Kelly, MD, FACS, International Relations Committee Chair.

Back row: Dr. Gramatica; Dr. Morris-Stiff; Dr. Semiglazov; Dr. Schinkel; and Dr. DiCarlo.

Board of Governors

The Board of Governors reelected **J. Patrick O'Leary, MD, FACS**, to an additional one-year term as Chair of its Executive Committee; **Timothy C. Fabian, MD, FACS**, to a one-year term as Vice-Chair of the Executive Committee; and **Julie A. Freischlag, MD, FACS**, to a one-year term as Secretary. Also elected to the Board of Governors' Executive Committee was **Mary Margaret Kemeny, MD, FACS**, of Jamaica, NY.

Awards and honors

In addition to the presentation of Honorary Fellowships and the Distinguished Service Award, other distinctions accorded during the Clinical Congress included the dedication of the 52nd volume of the *Owen H. Wangenstein Surgical Forum*

to **Henry Buchwald, MD, FACS**. The Committee for the Forum on Fundamental Surgical Problems dedicates the symposium each year to a pre-eminent surgical scientist who has made exceptional contributions to research and who is a role model for aspiring academic surgeons. **Robert N. Mentzer, Jr., MD, FACS**, Chair of the committee, presented the award to Dr. Buchwald (see photo, p. 21).

Additionally, each year the Fellows Leadership Society presents the Distinguished Philanthropist Award in recognition of magnanimous support of the College's programs. This year's award was presented to **Robert E. Berry, MD, FACS**, and **Margaret Valentine Berry** of Roanoke, VA (see photo, p. 22). Dr. and Mrs. Berry embody the spirit of philanthropy that the



CHUCK GIORNO PHOTOGRAPHY

This year's new Medical Student Program attracted more than 200 students interested in pursuing careers in surgery. These medical students attended the Clinical Congress and participated in special sessions that exposed them to the discipline of surgery and provided information on surgical training and careers. The 2002 students gathered in front of the San Francisco Yerba Buena Arts Center.

award was established to recognize, having given generously of their time, talents, and treasure to the College and to numerous social, civic, religious, and academic causes.

The 2002 National Safety Council's Surgeons Award for Service to Safety was presented this year to **Charles Aprahamian, MD, FACS**. As the citation specifies, Dr. Aprahamian "for 25 years has devoted his professional life to the prevention of injury and the training of surgeons, residents, and students in trauma care with distinction and personal commitment." Presenting the award on behalf of the National Safety Council were **J. Wayne Meredith, MD, FACS**, Chair of the Committee on Trauma, and **David B. Hoyt, MD, FACS**, president of the American Association for the Surgery of Trauma

and Medical Director of the ACS Trauma Programs (see photo, p. 22).

Lastly, the International Relations Committee, chaired by **Keith A. Kelly, MD, FACS**, hosted a luncheon to honor the 2001 International Guest Scholars. Physicians receiving the distinction this year are as follows: **Farhat Abbas, MD**, Pakistan; **Isidoro DiCarlo, MD**, Italy; **Luis Gramatica, Jr., MD**, Argentina; **Gonzalo Alberto Fernandez Naone, MD**, Uruguay; **William N. Sanchez Maldonado, MD**, Columbia; **Manuel Francisco Tanda Roxas, MD, FPCS**, Philippines; **Christian Werner Schinkel, MD**, Germany; **Vladislav V. Semiglazov, MD**, Russia; and **Gareth John Morris-Stiff, MB, BCH, FRSC(Eng)**, Wales (see photo, p. 24). □

Statement on ensuring correct patient, correct site, and correct procedure surgery

The following statement was developed by the College's Committee on Processes of Surgical Care and the Member Services Liaison Committee. It was approved by the Board of Regents at its adjourned meeting on October 11, 2002.

The American College of Surgeons (ACS) recognizes patient safety as being an item of the highest priority and strongly urges individual hospitals and health organizations to develop guidelines to ensure correct patient, correct site, and correct procedure surgery. The ACS offers the following guidelines to eliminate wrong site surgery:

1. Verify that the correct patient is being taken to the operating room. This verification can be made with the patient or the patient's designated representative if the patient is under age or unable to answer for him/herself.
2. Verify that the correct procedure is on the operating room schedule.
3. Verify with the patient or the patient's designated representative the procedure that is expected to be performed, as well as the location of the operation.
4. Confirm the consent form with the patient or the patient's designated representative.
5. In the case of a bilateral organ, limb, or anatomic site (for example, hernia), the surgeon and patient should agree and the operating surgeon should mark the site prior to giving the patient narcotics, sedation, or anesthesia.
6. If the patient is scheduled for multiple procedures that will be performed by multiple surgeons, all the items on the checklist must be verified for each procedure that is planned to be performed.
7. Conduct a final verification process with members of the surgical team to confirm the correct patient, procedure, and surgical site.
8. Ensure that all relevant records and imaging studies are in the operating room.
9. If any verification process fails to identify the correct site, all activities should be halted until verification is accurate.
10. In the event of a life- or limb-threatening situation, not all of these steps may be followed.

The American College of Surgeons offers this statement for consideration by surgeons and their hospitals and health organizations. It must be reviewed and modified as necessary to conform to the laws of the applicable jurisdiction and the circumstances of the individual hospital and health organization.

*R*eport of the Chair of the Board of Regents

by *Edward R. Laws, MD, FACS,*
Charlottesville, VA

It is a great pleasure for me to address you and particularly to welcome the new Initiates—to tell you a little bit about the College and the Board of Regents and what we have been doing over the past year.

First I would like to acknowledge the superb leadership that we have had at the American College of Surgeons with R. Scott Jones, MD, FACS, as our President, Thomas R. Russell, MD, FACS, as our Executive Director, and J. Patrick O'Leary, MD, FACS, as the Chair of the Board of Governors. All of these people are just superb individuals and all are dedicated to two objectives that I want to talk about. The first is reassembling and reinventing the House of Surgery so that all branches of the profession may speak together, and the second is keeping as our primary focus the welfare of the surgical patient.

I think we are making strides in achieving these goals, and I would just give you a few examples. One is the American College of Surgeons Oncology Group (ACOSOG), a very exciting project, which was put together by Samuel A. Wells, Jr., MD, FACS, and which is now thriving under a rather large grant from the National Cancer Institute. This oncology group, run by surgeons for surgical patients, is open to every Fellow of the College who wants to help conduct clinical trials that will benefit our patients with neoplastic disease.

Some wonderful news is that Dr. Jones has been hired to serve as the Director of the Division of Research and Optimal Patient Care. He will take the ACOSOG concept and spread it to other surgical patients, not only those who have neoplastic disease, but those who suffer from stroma and other conditions, such as hernia or vascular disease. These are exciting projects and plans that allow any surgeon, whether in academic or private practice, to enter his or her patient into a monumental trial that will give us answers to important questions in a short period of time.

Additionally, the College is trying to address problems common to all of surgery, including the issues of getting medical students to choose a surgical career, maintaining diversity within our surgical family, and somehow dealing with the duty hours restrictions that seem such a thorn in the side of effective surgical education. The Regents have listened carefully to the grass roots of surgery and have responded by helping to create what is called a 501(c)(6) organization. The American College of Surgeons Professional Association (ACSPA) will allow the College—which initially was formulated as a not-for-profit, tax-exempt organization without a business or political arm—to carry out appropriate political activities. The creation of the ACSPA is a monumental change in the philosophy of the College. It is a response to the desires of the Fellowship, and it is one that I think will help all surgeons deal with the very difficult problems we have in delivering effective service to our patients.

With that I will close and encourage you to read the reports of our other leaders, including one by Dr. O'Leary on page 28, and the other by Dr. Russell on page 29. □

*Dr. Laws is professor
of neurosurgery and
medicine, University of
Virginia Health
Sciences Center,
Charlottesville, VA.*



Report of the Chair of the Board of Governors

by **J. Patrick O'Leary, MD, FACS,**
New Orleans, NY

It is my privilege to serve as the Chair of the Board of Governors (B/G). The B/G is the grass roots of the College. There are approximately 260 Governors selected from various organizations and from chapters across the U.S. and around the world.

A year ago, I took over this job from Barbara L. Bass, MD, FACS, and there were some important changes that we thought needed to be made. First we were going to make some minor changes in the way the Governors interacted with the Executive Committee of the B/G, the way B/G committees were formed, and the way we got the message from the Governors to the Board of Regents.

The goals that we established for ourselves were that the College would form an organization with 501(c)(6) tax status, which could encompass a political action committee (PAC). Since then, the Regents have approved this proposal, and the College has succeeded in the development of the American College of Surgeons Professional Association and the ACS-SurgeonsPAC.

We also wanted a better instrument for the Governors to use in reporting so that we might be able to quantify the results of their observations. It was also important, I thought, to try to accomplish this goal electronically. In addition, we wanted to streamline the Governors' committees and reorganize them. We wanted to produce a mission statement for each of the Governors' committees so that we could then determine our goals and vision of success for these committees, and the mission statement would be a part of that process.

Additionally, we wanted to develop guidelines for the chapters. The chapters do not have guidelines right now, and it would, I thought, be helpful to the chapters to know what the College expects of them.

Further, with the help of Edward M. Copeland, MD, FACS, newly elected Vice-Chair of the

Board of Regents, we are looking at ways to streamline our annual meeting.

With regard to the new reporting mechanism, we asked all Governors to respond based on the 19 most common concerns from the last two decades. We developed a survey instrument, which was Web-based. I filled it out several times myself. The first four or five times I filled it out, I hit the tab key and it sent; then it went back to the beginning—so I had a little trouble figuring out my own instrument. Nothing is perfect!

We asked the respondents to indicate their degree of concern about each issue on a scale of one to 10, with 10 having the greatest impact and one having the least. Responses were submitted both electronically and in hard copy, and we tried to determine those issues that are really, really, really important. And then we wanted to figure out how and whether the relevance of each topic had changed from the previous year.

We divided the responses. A response of one to four meant that the issue really wasn't terribly important, five would be neutral, and a response of six through 10 would indicate that the subject was a major concern for the Governor.

continued on page 48

Dr. O'Leary is chair,
department of surgery,
Louisiana State Health
Sciences Center, New
Orleans, LA.



*R*eport of the *Executive Director*

*by Thomas R. Russell, MD, FACS,
Chicago, IL*

It is a real pleasure as I complete my third year as your Executive Director to report to you on the College's activities from my vantage point. I want to point out that this is your College. For the new Initiates, we hope to be your College throughout your whole professional life. We are obviously focusing on making the College relevant to you in the future and really on what is best for the surgical patient. That was Franklin Martin's goal in 1913, and that remains our goal today—to help you deliver better surgical care.

To make the College a more prominent voice for surgery, we need to be able to identify the issues and problems of concern to today's surgeon. I think J. Patrick O'Leary, MD, FACS, in his report on page 28, has nicely summarized for you the issues that the rank-and-file Fellows feel are very important.

To better meet the demands of our Fellows and ensure that the College remains relevant. We began a reorganization of the College two-and-a-half years ago. We went from having 12 separate departments to having four major divisions. So, we created these new divisions, and therefore, we needed some new leaders to head each division.

Ajit Sachdeva, MD, FACS, now leads the Division of Education. He is working to restructure the program planning committees around the medical students, the residents, and the accreditation requirements for continuing medical education. We have also formed four new task forces that are going to address the issues of communications skills, systems-based medicine, practice-based learning, and professionalism. We anticipate that these four task forces will do a great deal to further the educational products that we deliver, once again, with the goal of always helping our members to remain professional throughout their career.

The second division is that of Research and

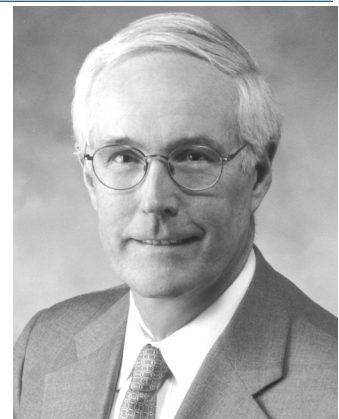
Optimal Patient Care. This growing area centers on the use of databases and data, clinical trials, best outcomes, and best practices, and I am so pleased that R. Scott Jones, MD, FACS, has accepted the position of division director. I am certain that this division will assist in ensuring that all surgeons can improve their practices based on outcomes and performance data.

We are also trying to increase the activities in Member Services to make this a relevant organization for all of you throughout your career.

The fourth area, of course, is Advocacy and Health Policy. This division basically addresses the systemic problems in medicine today, such as the issues of reimbursement, professional liability, tort reform, and so on—all those issues that, as Dr. O'Leary notes, are so important to surgeons and that surface continually in the Governors' reports.

I want to also acknowledge the staff. As you know, the College staff, both in Chicago and Washington, totals more than 200 individuals. I am certainly indebted to them for their hard work. It is their responsibility to take the Fellows' vision about what the College should do and turn it into action. You have a dedicated,
continued on page 48

Dr. Russell is Executive Director of the College.



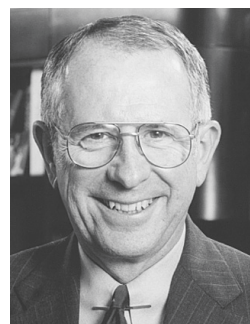
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Officers/Officers-Elect



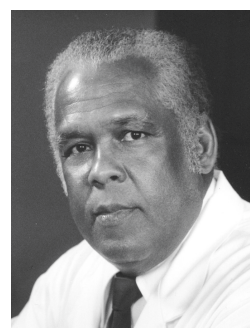
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President
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staff surgeon,
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Hospital,
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Amilu S. Rothhammer
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General surgery
Private practice,
Colorado Springs, CO



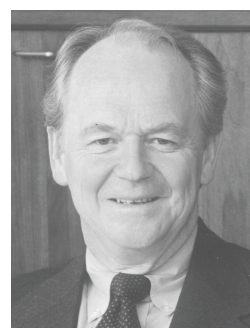
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John O. Gage
Secretary
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Board of Regents

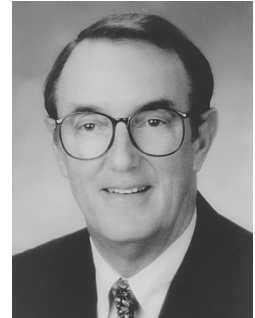


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Chair

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Edward M. Copeland III
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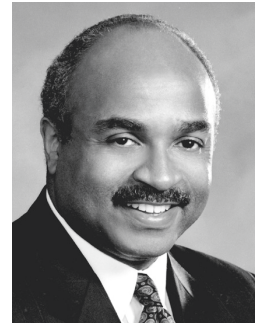


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William H. Coles

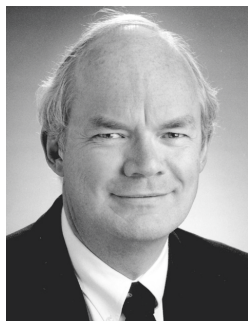
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Trauma and associate clinical
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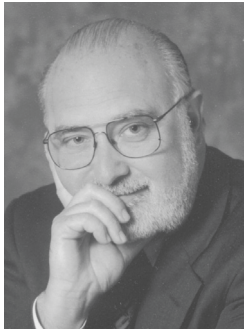


Board of Regents (continued)



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Gynecologic oncologist,
Mayo Clinic
Rochester, MN



In compliance...

...with HIPAA rules

by the Division of Advocacy and Health Policy

The key to complying with the privacy rule of the Health Insurance Portability and Accountability Act (HIPAA) lies in the documentation of privacy policies. Every surgical practice will need to develop a policy and procedures manual that documents accepted steps for handling confidential information to demonstrate their compliance with HIPAA privacy requirements. Not all items that must be included in the manual have been discussed in this column to date, but practices should start designing the process now. Upcoming columns will address other items that must be included in the manual.

The development and maintenance of the manual is a responsibility of the practice's privacy officer. The practice may already have instituted many of the policies and procedures required by HIPAA, in which case the privacy officer and the surgeon will just need to review existing materials to ensure that they comply and are centrally accessible. The manual may be maintained either on paper or electronically. It is probably advisable to have at least one copy of the manual in paper form in the event of a computer malfunction. The manual should include information regarding:

1. The practice's notice of privacy practices.
2. A list of the practice's uses and disclosures of confidential information for which an authorization is required and the exceptions to the requirement.
3. Policies for access to and amendment of confidential information, including guidelines for:
 - The information to which patients have access.
 - Who may request and/or amend the information.
 - Requests for information and the right to amendment.
 - How quickly a practice will respond to a request.
 - When the practice may deny access.
 - What to do if the source of the requested information is no longer available.

- How a patient may appeal an access or amendment denial.

4. Policies that outline how the practice will account for all confidential information disclosures that are made and a patient's right to receive an accounting of the disclosures.

5. A written guide to the process for patient complaints about your practice's policies and procedures.

6. A statement that informs patients that your practice will not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against them or their representatives for challenging the practice's privacy policies.

8. A statement that informs patients that the practice may not require them to waive their rights under the rule as a condition of the provision of treatment.

These seven items were discussed in this column in the October and November issues of the *Bulletin*. We will continue the discussion of additional items that must be included in the policies and procedures manual next month. □

ACS guidance on HIPAA issues is based on information contained in the "Small Practice Implementation Guide," version 1.2 (<http://snip.wedi.org/public/articles/index.cfm?Cat=17>), © 2001, The Workgroup on Electronic Data Interchange.

Keeping current

What's new in *ACS Surgery: Principles and Practice*

by Erin Michael Kelly, New York, NY

Following are highlights of recent additions to the online version of *ACS Surgery: Principles and Practice*, the practicing surgeon's first and only Web-based and continually updated surgical reference. A sample chapter and detailed information on *ACS Surgery*, including how to save \$20 on a subscription to the online version, is available by visiting www.acssurgery.com/learnmore.htm.

Keeping current in 2003 with *ACS Surgery: Principles and Practice*

ACS Surgery 2003 available in February. Save \$30 and receive a free three-month trial to www.acssurgery.com (a \$50 value) by reserving your copy today. For only \$199 (regularly \$229) you can be among the elite group of surgeons that subscribe to the only continually updated surgery textbook, *ACS Surgery*. Updated monthly online and annually in print, the *ACS Surgery* 2003 volume features 40 percent new and updated information to provide you with the most contemporary views on best practice and technique. Minimize complications, lower expenditures, and increase patient satisfaction with this unique reference. Call 1-800/545-0554 today to reserve your copy and be sure to request offer number V1202S.

Prefer online access only? For ACS Fellows, Associates, and Candidates, we are pleased to offer a \$20 discount on annual subscriptions to the online version of the textbook; you pay only \$179, instead of the customary \$199 rate. Visit www.acssurgery.com/learnmore.htm for more information and to save \$20 now.

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III. Trauma and thermal injury

5. Injuries to the chest. Asher Hirshberg, MD, and Kenneth L. Mattox, MD, FACS. In their chapter, Drs. Hirshberg and Mattox outline operative strategy and management tactics for handling penetrating and blunt thoracic injuries. They also highlight the underlying technical principles of gaining access and repairing traumatic injuries to the thoracic viscera, describing the pitfalls that await the inexperienced surgeon.

For example, Drs. Hirshberg and Mattox describe the technical keys to resuscitative thoracotomy. These are: (1) speed in entering the chest; and (2) avoidance of complex repairs or maneuvers until the patient is in the OR, where definitive repair of the injuries can be safely accomplished. The major pitfalls they describe are iatrogenic injuries to the phrenic nerve or to the heart during pericardiotomy and avulsion of an intercostal artery or esophageal perforation during aortic clamping. Care should be taken to avoid laceration of the inferior pulmonary vein during division of the inferior pulmonary ligament. If the resuscitative thoracotomy is successful, the patient regains a pulse and adequate blood pressure, and the transected internal mammary artery begins to bleed. This vessel should then be identified and both its transected ends ligated before closure.

In addition, the authors describe such innovative techniques as the pulmonary hilar twist, a new and simple method for vascular control of the hilum. As the name suggests, after the inferior pulmonary ligament has been divided, the injured lung is simply twisted around the hilum, so that its apex lies against the diaphragm while the base is in the upper chest. The twist is a rapid and effective temporary control technique that does not require precise anatomic identification of the lung and the hilar structures.

VI. Special perioperative problems

17. Hand infection. Thomas M. Sinclair, MD, FACS, FRCS, and H. Bruce Williams, MD. This

chapter provides an anatomically based approach (per Kanavel's pioneering work on defining the fascial planes) to the localization and proper surgical drainage of hand infections, as well as recommended antibiotic therapies.

Paronychia might require either antibiotics alone or in combination with drainage. When paronychia is diagnosed before pus is present, treatment with oral antibiotics and lukewarm soaks may terminate the infection. However, surgical drainage is required if an abscess has formed. The drainage procedure is done by simply placing the edge of a submucous elevator or a No. 11 scalpel blade into the nail sulcus to elevate the paronychial fold, thereby decompressing the abscess. The tips of fine curved scissors or a mosquito hemostat may also be used. If the abscess extends beneath the nail, a portion of the nail must be removed to allow the abscess to drain. It is not necessary to incise the paronychium or eponychium; such incisions can lead to deformity. Continued drainage is accomplished by placing a small piece of fine gauze in the sulcus. Antistaphylococcal antibiotics should also be given.

As Drs. Sinclair and Williams state in their discussion of antibiotic therapy choices, knowledge of the likely pathogen or pathogens is of course essential in planning antibiotic therapy for hand infections. The mode of injury, the presentation of the infection, and the status of the host will all help identify the most likely causative organism. Cultures of the exudates and Gram's staining should be performed routinely before empirical antibiotic treatment is begun. Preliminary antibiotic therapy should be focused on the most likely causative organism for the specific infection present.

In most home and industrial injuries, gram-positive organisms are the predominant pathogens. Because the majority of community-acquired *staphylococcus aureus* species have become penicillin-resistant, with a first-generation cephalosporin or a penicillinase-resistant penicillin is required to treat infections caused by these organisms. Traumatic injuries, although usually monomicrobial, may include gram-negative organisms if the injury involves contamination from soil. In such cases, an aminoglycoside should be combined with a first-generation cephalosporin and penicillin for adequate coverage.

IX. Miscellaneous concerns

2. *Infection control in surgical practice.* Vivian G. Loo, MD, MScA, and Peter McLean, MD, FACS. Drs. Loo and McLean review prevention of surgical site infections, including traditional control measures such as sterilization of surgical equipment, disinfection of the skin, use of prophylactic antibiotics, and expeditious operation. They also present the essentials of infection surveillance programs in the hospital setting and the components of an outbreak investigation.

Specifically on the subject of blood-borne infection control, the risk of transmission of HIV and hepatitis B virus (HBV) from patient to surgeon or from surgeon to patient has resulted in a series of recommendations governing contact with blood and body fluids. The risk of acquiring a blood-borne infection—such as HBV, hepatitis C virus, or HIV—depends on three factors: type of exposure to the blood-borne pathogen, prevalence of infection in the population, and the rate of infection after exposure to the blood-borne pathogen. Postexposure management has been discussed in recent CDC guidelines (<http://www.cdc.gov/mmwr/pdf/rr/rr5011.pdf>). Infection notification to surgeons has been shown by Cruse and Foord to have a positive influence on clean-wound infection rates. In a medical setting, Britt and colleagues also reported a reduction in endemic nosocomial infection rates for urinary tract infections, from 3.7 percent to 1.3 percent ($P < .0001$), and for respiratory tract infections, from 4.0 percent to 1.6 percent ($P < .001$), simply by keeping medical personnel aware of the rates.

Looking ahead

New and revised chapters scheduled to appear as online updates to *ACS Surgery* in the coming months include the following:

- "Ultrasonography: Surgical applications," by Grace S. Rozycki, MD, FACS.
- "Emergency department evaluation of the patient with multiple injuries," by Felix Battistella, MD, FACS.
- "Multiple organ dysfunction syndrome," by John C. Marshall, MD, FACS.
- "Organ procurement," by Charles M. Miller, MD, FACS, and Thomas R. Starzl, MD, FACS. □

Mr. Kelly is editor, *What's New in ACS Surgery: Principles and Practice*, *WebMD Reference*, New York, NY.

Socioeconomic tips of the month

Health plans for federal employees

by the Division of Advocacy and Health Policy

The Federal Employees Health Benefits (FEHB) Program provides benefits for 9 million federal employees, retirees, and dependents through contracts with more than 245 carriers. The program is coordinated through the U.S. Office of Personnel Management and offers coverage through fee-for-service plans, health maintenance organizations (HMOs), and preferred provider organizations (PPOs). It is the largest employer-sponsored health benefits program of its kind.

For the first time, federal employees are being offered a nationwide “consumer-driven” option by the American Postal Workers Union Health Plan, one of the FEHB programs. If individuals select this option they are enrolled in a PPO plan and are provided a personal care account (PCA) for “routine” treatment. The PCA, which is offered by Definity Health (<http://www.definityhealth.com>), covers 100 percent of eligible expenses, including medical and surgical services.

When the funds in the PCA (\$1,000 for an individual, \$2,000 for a family) are exhausted for a given year, coverage continues through the traditional PPO plan, which generally pays 85 percent of the cost for in-network care and 60 percent of the plan allowance for out-of-network care.

Two technical points: If a patient owes any payment for services, the physician will be notified through a remittance advice and then may bill the patient. Precertification of inpatient admissions and certain outpatient procedures is required.

In November of each year, federal employees are offered an “open season,” during which they may enroll or cancel participation in FEHB and change health plans or options. Those selections become effective January 1 of the upcoming year. If your practice has patients who are federal employees or their dependents, you may want to check if there are changes in their health care coverage when they make appointments at the beginning of 2003.

Around the corner

December

- The 90-day implementation period for the 2003 ICD-9-CM codes ends December 31, 2002.

January

- The 2003 Medicare fee schedule, which is ordinarily effective on January 1 of each year, has been delayed. The new and revised codes contained in the 2003 editions of CPT and HCPCS will not be effective until the implementation of the fee schedule. Check your Part B carrier newsletter and Web site, the ACS Web site (www.facs.org), and ACS NewsScope for updates.
- First-quarter update to Medicare correct coding edits.
- ACS-sponsored basic and advanced coding workshops for surgeons at the Louisiana chapter meeting, January 16-17, 2003. Visit the ACS coding workshop Web page at <http://www.facs.org/dept/hpa/workshops/cdwkshop.html> to register.

To learn more about FEHB plans, go to <http://www.opm.gov/insure/02/html/standard/links/index.html>. To check which federal employee plans may have changed in your area, go to <http://www.opm.gov/insure/health/03changes/index.asp>. Select your state to see if specific plans have been discontinued or if service areas where the plan is offered have been expanded or terminated. □

This column helps answer questions from Fellows and their staffs and provides useful tips for surgical practices. Developed by the College staff and consultants, this information will be accessible on our Web site. If there are topics that you would like to see addressed in future columns, please contact the Division of Advocacy and Health Policy by fax at 202/337-4271, or e-mail HealthPolicyAdvocacy@facs.org.

ACS executive staff welcomes Dr. Jones

ACS Director Thomas R. Russell, MD, FACS, recently announced that R. Scott Jones, MD, FACS, of Charlottesville, VA, has accepted the position of Director of the ACS Division of Research and Optimal Patient Care on a part-time basis.

Dr. Jones is currently the S. Hurt Watts Professor, department of surgery, University of Virginia Health System, Charlottesville, and just recently finished his term as President of the American College of Surgeons.

A Fellow of the College since 1975, Dr. Jones has served the ACS in numerous capacities. He has been a member of the College's Committee for the Forum on Fundamental Surgical Problems from 1979 to 1984, and served as Chair of that committee from 1983 to 1984.

Dr. Jones also served as Chair of the Medical Motion Pictures Committee (1986-1987) and Vice-Chair of the College's Program Committee (1989-1991). He served a two-term membership on the College's Board of Governors (1991-1997), and as a member (1991), Vice-Chair (1992-1994), and Chair (1994-1997) of the College's Advisory Council for Surgery. Dr. Jones also served as Chair of the ACS Nominating Committee of Fellows in 1998. Since 1991, he has been an active member of the Committee on Applicants and the Virginia Chapter's Membership Committee.

Dr. Jones earned a medical degree in 1961 from the Univer-



Dr. Jones

sity of Texas Medical Branch, Galveston. From 1962 to 1966 he was assistant resident in surgery and assistant instructor in surgery at the Hospital of the University of Pennsylvania School of Medicine. From 1967 to 1971, he served as clinical investigator and medical investigator for the Veterans Administration Hospital in San Francisco, CA, as well as assistant professor of surgery at the Uni-

versity of California, San Francisco.

From 1971 to 1981, Dr. Jones was associate professor and professor of surgery at Duke University Medical Center, Durham, NC. He began his tenure as S. Hurt Watts Professor and chairman of the department of surgery at the University of Virginia Health System in 1982.

His medical society memberships include the American Gastroenterological Association, Society for Surgical Oncology, American Surgical Association, Southern Surgical Association, Halstead Society, and the James IV Association of Surgeons. In 1986, he received the Ashbel Smith Distinguished Alumnus Award from the University of Texas Medical Branch and the Distinguished Alumnus Award from Duke University Medical Center in 1987.

Dr. Jones serves on the editorial boards of the *Journal of the American College of Surgeons*, *Annals of Surgery*, *Surgical Gastroenterology*, *Journal of Gastrointestinal Surgery*, *American Surgeon*, and *Digestive Surgery*.



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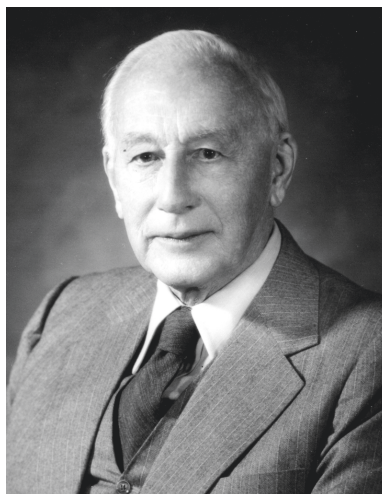
Just visit www.facs.org
and go to the "Members Only" tab

College receives bequest from estate of Past-President

The College has received a bequest from the estate of Claude E. Welch, MD, FACS, who served as the fifty-fourth President of the College from 1973 to 1974. Dr. Welch, a Fellow of 57 years who served as a Regent (1963-1972) and as Chairman of the Program Committee (1968-1972), passed away in March 1996 at the age of 89.

Originally drafted in 1953, the revocable trust named the College as recipient of a portion of the value of the trust following the death of Dr. Welch's spouse, Mrs. Phyllis P. Welch, in October 2001. Estimated at \$22,000 when the trust was established and reported to the College, the actual unrestricted gift received was in excess of \$103,000.

Norman M. Kenyon, MD, FACS, Chair of the Committee on Development's Subcommittee on Major and Planned Gifts, acknowledged the significant benefit of planned



Dr. Welch

gifts such as the revocable trust established by Dr. Welch. "Such trusts are a very effective method of providing a lasting legacy, while at the same time ensuring the financial security of loved ones," Dr. Kenyon said.

The College is currently strengthening its planned giving program and the Committee on Development is encouraging chapters as well as individual Fellows to explore current methods to ensure family financial security, receive major tax benefits, and provide for a substantial gift to the College as a legacy. Fellows are encouraged to attend seminars that are sponsored by the Development Program Office, or to contact the members of the Subcommittee on Major and Planned Gifts (see box below) for information regarding trusts and bequests as well as estate and tax planning programs currently available to both ACS chapters and individual Fellows.

Further information regarding seminars on planned giving may be obtained by contacting Fred Holzrichter at the College's Development Office at 312/202-5376.

Committee on Development Subcommittee on Major and Planned Gifts

Norman M. Kenyon, MD, FACS, *Miami, FL*,
Chair
Oliver H. Beahrs, MD, FACS, *Rochester, MN*
John E. DeLauro, MD, FACS, *Denver, CO*
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Online general sessions from the Clinical Congress

Offered by the American College of Surgeons
Division of Education

In an effort to meet the growing and ever-changing needs of our Fellows and a diverse surgical community, the Division of Education is offering six online general sessions from the Clinical Congress. These sessions are offered in the form of a Web cast at www.facs-ed.org

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What's Proven, What's Not**
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and Emergency Surgery:
New Applications**
- GS 23: Programa Hispanico**
- GS 34: Should Axillary Dissection
Be Abandoned?**
- GS 40: Management of Metastatic
Disease of the Liver**



Rural surgeon honored

Harry B. Neel, MD, FACS, a retired general surgeon from Albert Lea, MN, celebrated his 96th birthday this past May by being honored as one of that community's most distinguished citizens. Dr. Harry Neel is the father of H. Bryan Neel III, MD, FACS, a Past-Treasurer of the College.

The mayor of Albert Lea presented Dr. Neel with a proclamation designating May 14, 2002, as "Dr. Harry B. Neel Day" in appreciation for spending "his entire career practicing superb medicine and surgery in a rural setting, Albert Lea, MN, achieving a reputation for excellence in the practice of surgery and medicine for more than 40 years."

Dr. Neel graduated from Johns Hopkins Medical School and gained extensive experience as a military surgeon in the South Pacific during World War II. Following the war, he was instrumental in founding the Albert Lea Medical and Surgical Center. The center later became the Albert Lea Regional Medical Group, and today is Albert Lea Clinic—part of the Mayo Health System.

Dr. Neel was the first board-certified surgeon in southern Minnesota outside the Mayo Clinic. He was the 719th candidate to be certified by the American Board of Surgery. He introduced sodium Pentothal to his operating rooms shortly after it was used for the first time at the Mayo Clinic. He also recruited a surgical pa-



Dr. Harry Neel (left) on his 96th birthday with his son, Dr. Bryan Neel.

thologist from the Mayo Graduate School of Medicine to introduce frozen section techniques to the pathology lab of Naeve Hospital, and after taking several courses, he introduced modern respiratory therapy and a large number of other modern surgical support services to the hospital.

Dr. Neel's practice encompassed the entire spectrum of specialties—including general

abdominal, endocrine, colon and rectal, urology, orthopaedics, gynecology, and pediatric surgery.

Dr. Neel became a Fellow in 1942 and attended all ACS meetings for over 30 years. "Often he turned a College meeting into our family vacation," recalls Dr. Bryan Neel.

Since his retirement in 1983, Dr. Neel has remained a voracious reader of medical journals and American history.

Case filed 36 years after treatment

Malpractice verdict against neurosurgeon overturned

by Barry M. Manuel, MD, FACS, Boston, MA

The Professional Liability Foundation, the American College of Surgeons, the American Medical Association, and the Massachusetts Medical Society previously had all joined together in filing an amicus brief on issues of fraudulent concealment and decimating the statute of limitations. On August 27, 2002, the U.S. Court of Appeals for the First Circuit reversed a malpractice verdict against the late William H. Sweet, MD, FACS, and Massachusetts General Hospital based upon experimental care provided to terminally ill patients from 1960 to 1961. The lawsuit, brought in 1995, challenged the use of experimental boron neutron capture therapy (BNCT) on patients with glioblastoma multiforme.

The trial judge permitted the case to proceed despite the fact that it was filed nearly 35 years after the treatment, on the theory that the statute of limitations, which normally would have long since expired, was tolled (extended) because Dr. Sweet “fraudulently concealed his negligence” from the patients and their families, and they had only “discovered” his negligence in 1995 due to some references to the clinical trials in a presidential commission re-

port issued that year. The patients’ families alleged numerous causes of action against a number of parties involved in the experiments, including the U.S. Atomic Energy Commission and the Massachusetts Institute of Technology. The case against Dr. Sweet ultimately went to trial in 1999 on the claims of malpractice, wrongful death, and lack of informed consent.

Despite the fact that the experimental therapy had undergone several levels of review by hospital committees and the U.S. government prior to its use on these patients, the plaintiffs presented opinion testimony that the BNCT treatment was so flawed that it could not possibly have been of benefit to the patients and in fact was harmful to them. They claimed that Dr. Sweet knew that the treatment was without benefit, and nevertheless proceeded in order to advance medical knowledge. As evidence for this theory, among other things, plaintiffs argued that critical assessments of the therapy published by Dr. Sweet and his colleagues in peer review journals years *after* the experimental trials demonstrated that *at the time of the treatment* Dr. Sweet had not believed that the BNCT therapy could help *these*

terminally ill patients. The plaintiffs argued that there was not only a lack of informed consent but that Dr. Sweet affirmatively concealed from his patients his knowledge that the BNCT therapy was harmful to them (hence, the “fraudulent concealment” that extended the statute of limitations).

The jury found in favor of Dr. Sweet on the informed consent claim, but awarded substantial damages to the plaintiffs for malpractice and wrongful death. The defendants appealed the verdict on numerous grounds. Concerned about the potential impact of this case on ordinary medical practice and clinical research, the American College of Surgeons joined together with the Professional Liability Foundation, the American Medical Association, and the Massachusetts Medical Society in filing an amicus curiae, or “friend of the court,” brief in support of Dr. Sweet. Although several Massachusetts courts have opined that there might be situations where mere silence by a physician might constitute fraudulent concealment in a legal context, the courts have recognized that there is no duty for a physician to disclose facts or conclusions that he himself does not know or believe. The lower court’s rul-

ing in this case was problematic for physicians because it extended existing Massachusetts law in a way that was both unsupported by the evidence of the case and poorly thought out as a legal application of the fraudulent concealment doctrine to the realities of the physician-patient relationship. The amicus curiae brief focused on the misapplication of the fraudulent concealment doctrine, and outlined for the court the consequences such an unwarranted application of the law could have for medical practice and innovative clinical research. The brief also pointed out that the jury's verdict on informed consent flatly contradicted any argument that Dr. Sweet had fraudulently concealed pertinent medical information from his patients.

The Court of Appeals reversed the malpractice and wrongful death verdicts on the basis that *no reasonable jury* could have reached the verdicts rendered on the basis of evidence presented. The plaintiffs had failed to produce expert testimony that Dr. Sweet had departed from the relevant standard of care existing at the time the events occurred. The Court held that there was no evidence that Dr. Sweet believed that the BNCT treatment would not benefit these patients. The court also agreed with Dr. Sweet's attorneys and amici that the jury verdict on informed consent confirmed that the jury did not believe that Dr. Sweet had concealed information from his patients.

The court emphatically rejected the assertion that research articles published by Dr. Sweet and his colleagues after

the clinical trials demonstrated a consciousness of wrongdoing:

The purpose of medical research and trials is to learn from them and improve medical treatments for diseases, including treatment for the subjects of the trials. There would surely be a chilling effect on research in the medical field and deterrence of important progress in medical treatments if doctors and scientists could not frankly assess the successes and failures of their studies in published academic articles so that others can build on their work and learn from it.

While this case presented many unique features, the trial judge's decision to permit the case to proceed so many years after the events in question was perhaps the most significant. In addition to the significant burdens placed upon Dr. Sweet, who was 89 at the time of trial and unable to participate in his own defense due to illness, there was a concern that the trial judge's rulings could be used to undercut the statute of limitations in future cases and deter physicians from developing experimental therapies that could significantly improve future medical care. The Court of Appeals' decision affirmed the principle that a physician should be held to the standard of care existing at the time the medical care was rendered, and not subjected to liability many years later based upon present knowledge or opinion.

Attorney Pamela Heacock (Smith & Duggan LLP, Boston,

MA), principal author of the amicus curiae brief, noted that "the input from the medical community is incredibly helpful to the court in complex cases like this one. It was clear from both the oral argument and the final written opinion that the court valued the thoughtful participation of the amicus curiae. It was wonderful to have the support of the American College of Surgeons in this important effort."

This case marks the second time The American College of Surgeons has prevailed when it has joined an amicus action on medical issues of national importance.

This story was generated through the efforts of the Regents' Committee on Patient Safety and Professional Liability. Members of the committee believe that this and other articles published in the *Bulletin* will stimulate thought and possible action on a wider spectrum of issues related to patient safety and professional liability.

Dr. Manuel is professor of surgery and associate dean, Boston (MA) University School of Medicine. He is past Chair of the Regents' Committee on Patient Safety and Professional Liability, and currently serves as a consultant to the committee.

Contributions sought for 2003 Clinical Congress

Video-based education programs

The Committee on Video-Based Education, Division of Education, would like to invite submissions of videotapes of operations from general surgery and surgical specialties for consideration for presentation at the eighty-ninth annual Clinical Congress, to be held October 19-23, 2003, in Chicago, IL. Requirements for video submissions are posted at www.facs.org, or a videotape information form may be requested from Gay Lynn Dykman, Video-Based Education Administrator, at 312/202-5262 or gdykman@facs.org. The submission deadline for videotapes is **February 14, 2003**.

Papers sessions

The Program Committee, Division of Education, would like to invite submissions of abstracts for clinical paper presentations at the eighty-ninth annual Clinical Congress to be held October 19-23, 2003, in Chicago, IL. These paper presentations include clinical work that has not been previously presented or published elsewhere. (Basic laboratory research should be submitted to the Committee for the Forum on Fundamental Surgical Problems—see page 45.) *The Program Committee will consider only those abstracts where the principal author or a coauthor is a Fellow of the College.* The following instructions should be strictly adhered to:

1. The abstract should provide adequate information and objective data to evaluate the abstract properly.

2. The abstract must be limited to one 8-1/2" x 11" page, with 1" top and bottom margins and a left margin of 1-1/2". (It is permissible to single-space the abstract.)

3. At the top of the page please include the full title of the abstract and complete names and academic degrees of all authors, and indicate a surgical category based on the list below that best represents the overall topic of the paper.

- Adrenal Surgery
- Bariatric Surgery
- Breast Surgery
- Cardiac Surgery

- Colorectal Surgery
- Esophageal Surgery
- Gastric and Duodenal Surgery
- Liver, Biliary Tract, Pancreas Surgery
- Minimal Access Surgery
- Neurological Surgery
- Noncardiac Thoracic Surgery
- OB/GYN Surgery
- Perioperative and Critical Care Surgery
- Skin, Plastic and Reconstructive Surgery
- Small Intestinal Surgery
- Surgical Education
- Surgical Oncology
- Thyroid and Parathyroid Surgery
- Transplantation
- Trauma Surgery
- Vascular Surgery
- Other

4. At the bottom of the page, a footnote should be included to provide the principal author's mailing address, telephone number, e-mail, fax number, and, where pertinent, medical school affiliation and other institutions from which the work originates.

5. The original and one copy of the abstract should be submitted.

6. Photographs *should not* accompany the abstract.

7. The deadline for the receipt of abstracts is **March 3, 2003**. They should be mailed to: Camille Kidd Moses, Program Committee, Division of Education, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611.

Quality of the paper and a balanced program remain the committee's principal criteria for evaluating the abstracts received. Because of the competitiveness of the scientific program, it is unlikely that an author would be selected to present his or her work in two successive years. Questions regarding the submission process should be directed to Ms. Moses at 312/202-5325.

Scientific exhibits

The Program Committee, Division of Education, would like to invite submissions of abstracts for

the scientific exhibits at the eighty-ninth annual Clinical Congress to be held October 19-23, 2003, in Chicago, IL. The abstract submission form will be available in January. Please request the submission form from Lisa Richards, Division of Education, at tel. 312/202-5385 or via e-mail at lrichards@facs.org. The abstracts will be peer re-

viewed by the Program Committee and the most competitive abstracts will be accepted, based on the space available for the exhibits. There is no charge for the scientific exhibit display space. However, exhibitors must pay their own shipping and assembly costs. The submission deadline for abstracts is **March 3, 2003**.

Contributions to the 2003 Surgical Forum are requested

The Committee for the Forum on Fundamental Surgical Problems, Division of Education, invites surgical investigators in training to submit abstracts to be considered for presentation during the Surgical Forum at the eighty-ninth annual Clinical Congress, Chicago, IL, October 19-23, 2003. The Surgical Forum program highlights abstracts reporting original work performed by surgical investigators in training.

Accepted abstracts will appear in a supplement of the *Journal of the American College of Surgeons (JACS)*, a publication recognized by *Index Medicus*. Full manuscripts may be subsequently submitted to *JACS* or other journals. Abstracts are reviewed and selected by the Forum Committee for each surgical specialty. *Abstracts are graded by committee members most familiar with the abstract's designated category*. Following the grading, the full committee selects the abstracts to be presented at the Clinical Congress.

The submission process will begin on December 1, 2002, and the deadline for submission is

March 1, 2003. Notice of acceptance or rejection will be mailed to the principal author of each abstract by May 1. Please read the following specifications.

Submission guidelines

Abstracts should be submitted via the ACS web site at: <http://www.facs.org/sfabstracts/index.html>.

- Submission begins on December 1, 2002. A reference number will be generated upon receipt of the electronic submission.

- The deadline for submissions is 5:00 pm (CST) **March 1, 2003**.

- Abstracts may not be submitted to any other venue; if duplicate submission is detected the abstract will be deleted before review.

Notification of selection

The principal author will be notified in writing about abstract selection by May 1, 2003. If you have questions, please contact kkoenig@facs.org or directly at 312/202-5336.

2004 Travelling Fellowship available

The International Relations Committee of the American College of Surgeons announces the availability of a travelling fellowship, the Australia and New Zealand Chapter of the American College of Surgeons Travelling Fellowship for the year 2004.

Complete details and the requirements are avail-

able upon request from the International Liaison Section, ACS, 633 N. Saint Clair St., Chicago, IL 60611-3211. They are also posted on the College's Web site at www.facs.org. The requirements will be published in their entirety in the January 2003 issue of the *Bulletin*.

Clinical Congress Web cast offers Category 1 CME credits online

Six general sessions from the 2002 Clinical Congress are now available via a Web cast on the American College of Surgeons' Web site. Sponsored by the College's Division of Education, the program offers practicing surgeons a flexible and convenient way to obtain Category 1 CME credits and is the first step in establishing a comprehensive E-Learning Program.

Sessions include:

- New Technology: What's Proven, What's Not
- Patient Safety
- Damage Control in Trauma and Emergency Surgery: New Applications

• Programa Hispanico:

Section 1: Surgical Management of Breast Cancer

Section 2: Status of Liver Transplantation in Latin America

Section 3: Bariatric Surgery Update.

Section 4: Management of Pancreatic Cancer."

• Should Axillary Dissection Be Abandoned?

• Management of Metastatic Disease of the Liver

For further details and to view the program catalog, visit <http://www.facs-ed.org/>.

Coding workshops

The American College of Surgeons will sponsor a series of basic and advanced CPT and ICD-9-CM coding workshops during 2003. **Foundations in CPT and ICD-9 CM Coding** and **Mastering Surgical and Office-Based Coding** will be offered back-to-back in five locations. These one-day workshops are designed for all surgeons and their staffs and will be presented by representatives of KarenZupko and Associates.

<u>Level</u>	<u>Date</u>	<u>City</u>	<u>Level</u>	<u>Date</u>	<u>City</u>
Basic	January 16, 2003	New Orleans, LA	Advanced	May 30, 2003	Atlanta, GA
Advanced	January 17, 2003	New Orleans, LA	Basic	July 17, 2003	Boston, MA
Basic	March 27, 2003	Los Angeles, CA	Advanced	July 18, 2003	Boston, MA
Advanced	March 28, 2003	Los Angeles, CA	Basic	September 18, 2003	St. Louis, MO
Basic	May 29, 2003	Atlanta, GA	Advanced	September 19, 2003	St. Louis, MO

The American College of Surgeons designates each coding workshop for up to a maximum of seven hours in Category 1 credit towards the Physician's Recognition Award of the American Medical Association. Visit the ACS Web site for more information about the workshops, locations, and online registration at <http://www.facs.org/dept/hpa/workshops/cduksbop.html>. ACS coding workshops will also be offered as postgraduate courses during the College's 2003 Spring Meeting and Clinical Congress, so watch your mail for them in the coming weeks and months.

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REPORT OF THE CHAIR OF THE BOARD OF GOVERNORS, from page 28

Now what about change? A response of one to four in this area meant that the situation had gotten a little better, a five would mean that it hadn't really changed at all, and a response of six through 10 would indicate that the impact had really changed for the worse from last year.

We found that with regard to the issue of physician reimbursement, 88 percent of all Governors who responded rated this issue between six and 10. It is really bad out there, folks, and according to the responses we received, it is getting worse. So now we have been able to say that physician reimbursement is of great concern and the problem is getting worse.

With regard to professional liability, 80 percent of the respondents thought that this issue rated a six to a 10, and oh, by the way, it is getting worse.

Now, for reimbursement and malpractice, I will bet you that most of the people who responded with a one to a four either were in the

military or were from international chapters.

What about Medicare and Medicaid? They were ranked at number three as a concern and, again, 80 percent of the Governors felt that these issues rated between six and 10, and are also getting worse. Of particular concern, based on the respondents' comments, was the 5.4 percent decrease in reimbursement from Medicare this year.

Finally, tort reform closed out the top four issues of concerns, with about 74 percent of the respondents rating it between six and 10. The respondents reported that this problem is no better than it was last year, but it maybe a little bit worse.

So that is how I attempted to modify a little bit the way the Governors reports are submitted. This system, I think, gives us a little stronger handle on what the Governors really feel is having an impact on their practices. □

REPORT OF THE EXECUTIVE DIRECTOR, from page 29

hard-working staff, and I am most appreciative of them for helping to implement some of the actions our Fellows believe are necessary.

In this day and age, if I didn't say something about the fiscal affairs of the College, I would not be fulfilling my duties. I can assure you that from my viewpoint and based on my knowledge of our fiscal affairs, the finances of the College are on solid ground. For what it is worth, we have been audited, and we received a clean record from the auditors. Additionally, we retain ownership of four significant buildings, three in Chicago and the Washington Office. We also are well endowed through various activities of the past as well as philanthropic activities. Hence, the College is in a very solid financial position and hopefully will be able to respond to the challenges we will be facing in the future, many of which will be costly but necessary to keep the American College of Surgeons a relevant and pertinent organization.

In conclusion, I want to welcome the approxi-

mately 1,500 Initiates who became Fellows of the College in October and hope that you will have a lifelong relationship with the College. I anticipate that in your professional journey, one that will span more than 20 or 30 years, you will find the College to be a useful organization, one that will allow you to remain true to our patients, true to the Hippocratic Oath, and true to all the elements of professionalism that are so important in this day of great accountability. It will be the College that will have the longest relevance in your career—more than just four years of college and four years of medical school—in terms of enhancing your education, helping you to analyze your practice, and supporting you in changing the system in which we all have to practice.

Finally, I want to thank the Fellows for your participation in the activities of the American College of Surgeons. It is your ideas and your suggestions that provide the basis on which we design and implement our programs. □

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Syllabi Select is a CD-ROM containing 14 postgraduate course syllabi from the 2002 Clinical Congress. These syllabi—selected and packaged for your convenience—can be purchased by calling 312/202-5474 or through the College's Web site at <http://secure.telusys.net/commerce/current.html>

The 2002 Syllabi Select CD-ROM is priced at \$75. There is an additional \$12 shipping and handling charge for international orders.

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- PG 16:** Diseases of the Liver, Biliary Tract, and Pancreas
- PG 17:** Vascular Surgery: Technical Tips That Enhance Surgical and Endovascular Outcomes
- PG 18:** Thoracic Surgery
- PG 19:** Gastrointestinal Disease
- PG 20:** Minimal Access Surgery
- PG 21:** Essential Technical Elements in Trauma
- PG 22:** Cardiac Surgery
- PG 24:** Colon and Rectal Surgery
- PG 26:** Surgical Infection and Antibiotics
- PG 27:** Breast Disease
- PG 28:** Plastic Surgery: Management of Devastating Defects of the Abdomen and Perineum
- PG 29:** Pediatric Surgery: Esophageal Disorders and Anomalies in Infancy and Childhood
- PG 30:** A Surgeon's Personal Guide to Risk Management and Trial Participation



Chapter news

by Rhonda Peebles, Chapter Services Manager, Division of Member Services

To report your chapter's news, contact Rhonda Peebles toll-free at 888/857-7545, or via e-mail at rpeebles@facs.org.

Chapters observe 50th anniversaries

Recently, two chapters observed their 50th anniversaries: the Alabama Chapter, June 13-15, and the Tennessee Chapter, August 26-28. The Alabama Chapter 50th Annual Meeting took place in Point Clear; Thomas R. Russell, MD, FACS, the College's Executive Director, presented a commemorative charter to the Alabama Chapter.

The Tennessee Chapter continued its tradition of meeting at Fall Creek Falls State Park. Dr. Russell attended the three-day event (see photo, top right), during which three paper competitions for residents were held. The recipients of awards in these competitions included:

- Trauma Competition: First place—Wright Jernigan, MD, University of Tennessee (UT), Memphis.
- Jabbour-Basic Science Competition: First place—John Pacanowski, MD, UT, Knoxville.
- Clinical Science Competition: First place—Glen Balch, MD,* Vanderbilt University.

Ohio and Hawaii host annual meetings

The Ohio Chapter conducted its 47th Annual Meeting May 9-11. A hands-on course on laparoscopic ventral herniorrhaphy began the three-day education program, which also featured posters and presentations by residents and Ohio Chapter members. Claude H. Organ, Jr., MD, FACS, the College's President-Elect, presented the Ohio Oration during the annual business meeting. Also at the meeting, Richard Fratianne, MD, FACS, was awarded the Chapter's Distinguished Service Award (see photo, bottom right). Finally, the Ohio Chapter received an award of appreciation from



Tennessee Chapter: Dr. Russell (right) presented the 50th anniversary commemorative charter to David Walters, MD, FACS, chapter President.



Ohio Chapter: Dr. Fratianne (left), Past-President of the chapter and a former ACS Governor, receives the Ohio Chapter's Distinguished Service Award from Mark A. Malangoni, MD, FACS, a Governor-at-Large representing the Ohio Chapter.



Hawaii Chapter, left to right: Michael Sawyer, MD; Simon H. Telian, MD; Elizabeth Sawyer, MD; Hideko Yamauchi, MD; Danny Morito Takanishi, Jr., MD, FACS; Jeffrey Lee, MD, FACS; Della M. Linn, MD; and Philip T. Siegert, MD, FACS.

the College's Development Committee for its contributions to the endowment funds. Other activities included: (1) reports from chapter lobbyist Dan Jones, president of Capitol Consulting Group, regarding trauma center verification and tort reform; and (2) a report on the 2002 surgery resident debt survey, which indicated that the average debt for Ohio surgery residents was \$81,260; 5 percent of residents' debt exceeded \$100,000, 22 percent had debt exceeding \$150,000, and 11 percent had debt that exceeded \$200,000.

Meanwhile, the Hawaii Chapter met August 9-11 in Oahu and a variety of topics were presented during the education program. Philip T. Siegert, MD, FACS, presented several sessions dealing with ambulatory surgical care, including regulations governing facilities. In addition, Dr. Siegert met with surgical residents and other physicians from the University of Hawaii and Tripler Army Medical Center programs (see photo, above).

New hotline for all ACS members

Since October, all College members—Fellows, Associate Fellows, and Candidates—have been able to use a new toll-free number to contact

the College—800/621-4111. Chapters are encouraged to alert their members to this new service.

2003 chapter leadership conference planned

To realize the goal of having a greater influence on health care policymaking, the 2003 Leadership Conference for Chapter Officers and Young Surgeons will be held in Washington, DC, June 22-24. Various education sessions will focus on legislative and rule-making processes and an update on the College's health policy priorities, as well as other activities.

Special sessions are planned for chapters' management staff and young surgeon representatives. In addition, all chapter leaders and young surgeons will have an opportunity to visit with their members of Congress during the three-day conference. For more information, contact Rhonda Peebles at 888/857-7545, or via e-mail at rpeebles@facs.org.

Chapter anniversaries

Month	Chapter	Years
November	Arkansas	50
	Chile	51
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